CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10859	**Date: June 17, 2021**
	Change Request 11942

This Transmittal is no longer sensitive and is being re-communicated. This instruction may now be posted to the Internet. Transmittal 10466, dated November 13, 2020, is being rescinded and replaced by Transmittal 10859, dated, June 17, 2021 to remove the provider education business requirement 11942.12. All other information remains the same.

SUBJECT: Direct Contracting Model - Professional and Global Options: Homebound Home Health Waiver and Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit - Implementation - This CR Rescinds and Fully Replaces CR 11863.

I. SUMMARY OF CHANGES: The Direct Contracting Model (DCM) creates a new opportunity for the Centers for Medicare & Medicaid Services (CMS) to test an array of financial risk-sharing arrangements, leveraging lessons learned from other Medicare Accountable Care Organization (ACO) initiatives, such as the Medicare Shared Savings Program (SSP) and the Next Generation ACO (NGACO) Model, as well as innovative approaches from Medicare Advantage (MA) and private sector risk-sharing arrangements. As an ACO-like Model, DCM allows participating organizations to take on the financial risk for Medicare Part A and B expenditures (all institutional and professional claims) for a defined population of fee-for-service Medicare beneficiaries over a defined period of time (5 years, separated into 1-year increments called Performance Years (PYs).

Under DCM, the payment for Medicare services provided to aligned beneficiaries through traditional FFS claims processing rules will remain unchanged. However, DCM has built in two types of flexibilities to help DCEs and their providers better coordinated care (note: each is discussed in more detail later in the document):

- Payment Mechanisms (PMs) allow Providers to elect reduced FFS claim payments in return for their DCE receiving predictable prospective monthly payments. These mechanisms function similarly to Population Based Payment (PBP) and AIPBP (All-inclusive) in NGACO. In DCM, there are three PMs: Total Care Capitation (TCC), Professional Care Capitation (PCC), and Advanced Payment Option (APO). More discussion of the policy goals and operational details is included below.
- Benefit Enhancements (BEs) are waivers to Medicare payment rules that offer flexibility for care coordination and delivery. They allow beneficiaries to receive services and Providers to receive payments for those services that are not otherwise covered by Medicare. There are two BEs included in this Change Request (CR): Home Health Homebound Waiver and Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit.

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021 - Analysis, Design, and Some Coding; April 5, 2021 - Complete Coding, Testing, and Implementation

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Demonstrations

Attachment - Demonstrations

Pub. 100-19	Transmittal: 10859	Date: June 17, 2021	Change Request: 11942

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EFFECTIVE DATE: April 1, 2021
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IMPLEMENTATION DATE: January 4, 2021 - Analysis, Design, and Some Coding; April 5, 2021 - Complete Coding, Testing, and Implementation

I. GENERAL INFORMATION

A. Background: The Direct Contracting Model (DC) creates a new opportunity for the Centers for Medicare & Medicaid Services (CMS) to test an array of financial risk-sharing arrangements, leveraging lessons learned from other Medicare Accountable Care Organization (ACO) initiatives, such as the Medicare Shared Savings Program (SSP) and the Next Generation ACO (NGACO) Model, as well as innovative approaches from Medicare Advantage (MA) and private sector risk-sharing arrangements. As an ACO-like Model, DC allows participating organizations to take on the financial risk for Medicare Part A and B expenditures (all institutional and professional claims) for a defined population of fee-for-service Medicare beneficiaries over a defined period of time (5 years, separated into 1-year increments called Performance Years (PYs).

This Change Request supplements CR 11768 and provides additional detail and business rules surrounding the Homebound Home Health Waiver and the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit. CR 11768 also establishes the Direct Contracting Model demo code, "92."

Additional detail on Homebound Home Health Waiver (BE Indicator "9")

Background

DC seeks to create a waiver of the homebound requirement for the reimbursement of home health services. Traditional Medicare currently provides reimbursement for home health care services if a beneficiary meets the following criteria below, as outlined in §1814(a)(2)(c) and §1835(a)(2)(a):

1. The beneficiary either (a) must need the assistance of a supportive device, special transportation, or another person to leave their residence OR (b) have a condition that makes leaving his or her home medically contraindicated; and
2. There must be a normal inability to leave the home AND leaving home must require a considerable and taxing effort.

Under Traditional Medicare, homebound beneficiaries are entitled to reimbursement for the following Home Health services: skilled nursing care; home health aides; physical therapy; occupational therapy; speech-language pathology; medical social services; routine & non-routine medical supplies; and durable medical equipment. However, the homebound requirement focuses on a beneficiary's functional limitations rather than the underlying health condition or comorbidities often present in this population. Unless homebound status is certified, skilled nursing care services in the home are not eligible for Medicare reimbursement for

beneficiaries, even if confined to their home in practice. The purpose of this waiver is to target beneficiaries with multiple chronic conditions who are at risk of an unplanned inpatient admission by not requiring the homebound requirement for Home Health service reimbursement.

Implementation Approach

To qualify for home health services under the homebound home health waiver, beneficiaries must (1) meet all required qualification criteria for home health services under 42 C.F.R. § 409.42 except for the homebound requirement; and (2) the rendering providers must verify the beneficiary meets the criteria outlined in the Homebound Home Health Waiver Form developed by CMS specifically for this waiver in the DC Model.

The SSMs are asked to (1) activate this BE; (2) ignore the homebound requirement for home health services but otherwise follow requirements regarding Medicare coverage and payment for home health services (i.e., pay the claim if it meets all require criteria aside from the homebound requirement); and (3) ensure the home health services are rendered in beneficiary's home or place of residence during the certified episode of care period.

CMS will use the form mentioned above to ensure the waiver is used appropriately (note: the SSMs will not be responsible for receiving the Homebound Home Health Waiver Form or auditing providers who enroll and use this hospice waiver, i.e. performing the clinical determination of the beneficiary's health status). DC Participant Providers and Preferred Providers will use the Homebound Home Health Waiver Form as well as their own clinical judgement to determine if a beneficiary is eligible and would benefit from receiving home health services. Using this form, providers will be responsible for verifying to CMS that (1) the aligned beneficiary had at least one unplanned inpatient admission or emergency department visit in the prior 12 months; (2) the aligned beneficiary have at least two chronic conditions; and (3) the aligned beneficiary meet one of the three following criteria: inpatient service utilization, frailty, and/or social isolation.

Additional detail on Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit (BE Indicator "B")

Background

Beneficiaries who elect hospice care generally waive their right to Medicare coverage for treatment of their terminal condition and related conditions when not provided by a designated hospice. This limits the ability of terminally ill beneficiaries from receiving curative services or "conventional care" and steers them towards palliative care.

To ease care transitions and expand beneficiary choice, DC aims to waive the requirement that beneficiaries who enroll in the Medicare Hospice benefit forgo their right to receive curative care as a condition of enrolling in Hospice. Under this waiver, DCEs would work with the beneficiary's hospice providers, as well as non-hospice providers, to define and provide CMS a set of concurrent care services related to a hospice enrollee's terminal condition and related conditions that are appropriate to provide on a transitional basis and align with the beneficiary. For example, this may include the continuation of chemotherapy services, blood transfusions, or dialysis in the form of "bridge services", or permit a course of therapy during the transition into hospice. However, this hospice waiver does not change the beneficiary's eligibility criteria for the Medicare Hospice benefit or the requirement that the elected hospice provider provide all services and levels of care available under the Medicare Hospice benefit.

Implementation Approach

To enable this hospice wavier, the SSMs are asked to 1) activate this BE; 2) discontinue existing claims-based edits to prevent non-hospice claims from processing while a beneficiary is Hospice-enrolled for hospice and non-hospice organizations aligned to the DCE; 3) reimburse claims related to concurrent care

provided to Hospice-enrolled beneficiaries from organizations aligned to the DCE that are otherwise appropriate for payment under Traditional Medicare. The DCE would pay only for concurrent services provided by designated DC Participants or Preferred Providers as specified in the beneficiary's plan of care.

Similar to the approach used for the 3-Day Skilled Nursing Facility Rule Waiver, DCEs would identify the hospices with whom they would partner in this BE. Likewise, DCEs will be able to identify non-hospice providers included under this BE. These partner hospices and non-hospice providers must be either DC Participant Providers or Preferred Providers.

B. Policy: Section 1115A of the Social Security Act (the Act) establishes CMMI to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and CHIP spending while maintaining or improving the quality of beneficiaries' care. Section 1115A(d)(1) of the Act authorizes the Secretary to waive such requirements of Title XVIII of the Act as may be necessary solely for purposes of carrying out the testing by CMMI of certain innovative payment and service delivery models, including the DC Model.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11942.1	Effective for Dates of Service on or after April 1, 2021, the contractor shall add two new benefit enhancement indicators for the Direct Contracting Model • '9' - Home Health Benefit Enhancement • 'B' - Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit					X	X		X	IDR
11942.2	Contractors shall allow and process DC Homebound Home Health claims when: • The claim includes an aligned provider AND • The claim-header includes an aligned beneficiary to the same DC Entity Identifier as the provider AND • The aligned Provider elected BE indicator "9" as indicated on the Provider Alignment File AND • The From date is on or within the Beneficiary Effective Start Date and 90 days after the Beneficiary Effective End Date as indicated on the ACOB Auxiliary File AND • The From date on the claim-header is on or within the Provider's Effective Start Date and Provider's Effective End Date			X		X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11942.3	The contractor shall allow Homebound Home Health claims (TOB 032x, excluding TOB 0322) without documentation of the homebound coverage criterion being met when: • The Provider elected BE indicator '9' as indicated on the Provider Alignment File AND • Demo code '92' has been appended to the claim			X						
11942.4	Contractors shall display MSN Message 63.10 on DC claims where BE indicator "9" or "B" is present on the claim-header or claim-detail. *You got this service from a provider who coordinates your care through a Direct Contracting Entity (DCE). For more information about care coordination from your DCE, talk with your doctor or call 1-800-MEDICARE (1-800-633-4227).* Spanish - *Recibió este servicio de un proveedor que coordina su atención a través de una Entidad Contratante Directa (DCE). Para obtener más información sobre la coordinación de la atención de su DCE, hable con su médico o llame al 1-800-MEDICARE (1-800-633-4227).*	X	X	X		X	X			
11942.5	The contractor shall process Benefit Enhancement Indicator '9' received on HUHH (Home Health) claims with Demo 92.								X	IDR
11942.6	The contractor shall process Benefit Enhancement Indicator 'B' received on HUIP (Inpatient), HUOP (Outpatient), HUHH (Home Health), and HUBC (Part B) claims with Demo 92.								X	IDR
11942.7	The contractor shall verify that the Beneficiary is in a Hospice Election period in order for the claim to be eligible to carry Demo code '92' and BE indicator of 'B'.								X	
11942.8	The Contractor shall create a new reject when: • Demo '92' is present on the claim AND								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The Provider elected BE indicator 'B' as indicated in the Provider Alignment File AND • The aligned Beneficiary is not in a Hospice Election period for the detail line DOS on a professional claim OR • The aligned Beneficiary is not in a Hospice Election period for the From date on an institutional claim									
11942.8.1	Upon receipt of the new reject information, the Contractor shall remove the BE indicator 'B' from the claim if the Beneficiary was determined to not be in a Hospice Election period for the detail DOS on a professional claim or a From date on an institutional claim.* **Note: *** • **Demo code '92' should remain on the claim.**					X	X			
11942.9	The contractor shall apply condition code '07' to non-hospice institutional claims when: • The From date on the claim-header is on or within a Beneficiary's Hospice Election period AND • The From date is on or within the Beneficiary Effective Start Date and 90 days after the Beneficiary Effective End Date as indicated on the ACOB Auxiliary File AND • The From date on the claim-header is on or within the non-Hospice Provider's Effective Start Date and Provider's Effective End Date AND • Benefit enhancement indicator of "B" is present on the claim-header					X				
11942.9.1	The contractor shall move all units and charges back to covered units and charges on the claim, and send the claim to CWF for processing.					X				
11942.10	The contractor shall process the Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	for professional claims when: • The claim-line includes an aligned provider (Billing TIN-iNPI) AND • The claim-line includes an aligned beneficiary to the same DC Entity Identifier as the provider AND • The Provider elected BE indicator 'B' as indicated on the Provider Alignment File AND • The DOS is on or within the Beneficiary Effective Start Date and 90 days after the Beneficiary Effective End Date as indicated on the ACOB Auxiliary File AND • None of the claim-detail modifiers is "GW" * **Note: *** • **GW = Condition/service not related to the hospice patient's terminal condition.**									
11942.10.1	The contractor shall use hospice information supplied by CWF through BDS and/or CWF responses to identify the hospice associated with the beneficiary's hospice election based on the claim detail DOS.						X			
11942.10.2	The contractor shall override the CWF edit for professional claims overlapping a hospice election when the criteria for the DC model benefit enhancement is met.						X			
11942.11	Integrated testing shall be performed between CWF and the SSMs during the alpha period of this CR.					X	X		X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sarah Wheat, sarah.wheat@cms.hhs.gov , Patrick Welsh, patrick.welsh@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 2

Home Health Homebound Waiver Guidelines			
Beneficiaries may be eligible for the home health homebound waiver if they are aligned to a Direct Contracting Entity, have two chronic conditions, **and** meet one of the four following criteria: inpatient service utilization, frailty, social isolation, and/or other. Direct Contracting Providers will use the form, as well as their own clinical judgement to determine if a beneficiary is eligible and will benefit from receiving home health services.			
Provider Information			
Referral's Name:	(Last)	(First)	NPI? # ( ) -
Patient's Name:	(Last)	(First)	Phone # ( ) -
Medicare Beneficiary Identifier (MBI):			
Reason for recommending home health (please provide a brief description): _____ _____			
Referral source: ❒ PCP ❒ Specialist, Type: _____ ❒ Hospital/Emergency Department❒ Other: _____			
Do you have an existing patient relationship with referred patient (i.e. seen once in the past year)? ❒ Yes ❒ No			
Direct Referral Assessment Checklist			
Requirement: Clinical Eligibility			
Help Text: An aligned beneficiary must have at least two or more chronic conditions. Questions to consider when determining if a beneficiary has a chronic condition: Was the beneficiary diagnosed with a condition that requires ongoing assessment and treatment that is documented in the beneficiary's plan of care? Please also reference the Center for Medicare and Medicaid Services list of chronic conditions for examples of eligible clinical conditions. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CC_Main.			
Criteria 1: Inpatient Service Utilization			
Help text: Aligned beneficiaries must have at least one unplanned inpatient admission or emergency department visit within the last 12 months.			
❒ Inpatient Admission			
❒Emergency Department Visit			
❒ **Not Met**			
Criteria 2: Frailty (Defined by one of the below evidence-based tools			
Help text: DCEs may use one of five tools to measure beneficiary frailty for the purposes of recommending home health care. CMS has established a threshold for each tool that would qualify a patient for this benefit enhancement. Please select the tool and threshold you used to evaluate this patient and determine their appropriateness for home health services.			
❒ Score of 4 or less on Katz ADL			
❒ Score of 3 or greater on the Physical Frailty Phenotype tool			
❒ Score of 3 or greater on the FRAIL Scale			
❒ Score of 60% or less on the Palliative Performance Scale			
❒ Score of 60% or less on the Karnofsky Performance Scale			
❒ **Not Met**			

Criteria 3: Social Isolation (e.g. lack of family and/or friend network(s), minimal community contacts, absence of social engagement)
Help text: Social isolation can be defined structurally as the absence of social interactions and relationships, or resources provided by other persons. These resources, which may include emotional, social, physical, financial, and other types of care, cover a broad array of individuals and institutions as the source of this care. Social isolation is defined and then measured by the strength of the older person's existing social network and the characteristics of the individuals and institutions providing support to him or her through this network. The absence or weakness of the social support network forms the basis for identifying individuals who are socially isolated.[1]
Who does the patient live with? ❒ Alone ❒ Family ❒ Friends ❒ Other Does the patient see or talk to family members and friends more than two times per week? ❒ Yes – most weeks ❒ Some weeks ❒ Almost never Does the patient have other sources of social support ❒ Group activities ❒ Community association ❒ Adult Day Care ❒ Service or civic organization ❒ Religious institution ❒ Other In your summary judgement, based on the information above, is this patient experiencing social isolation? ❒ Yes ❒ No
Criteria 4: Other
Help text: If none of the criteria above are applicable, please describe why you think this beneficiary would benefit from receiving home health care. We encourage providers to use their best clinical judgement to attest to a beneficiary's need for these services. Please note, there is no incentive for DCEs to provide these services unnecessarily.
In your summary judgement, based on the information above, is this patient in need of home health care services? ❒ Yes ❒ No
Submission
Do you attest that the information provided in the form is accurate? ❒ Yes ❒ No Please keep this completed form in the patient's records. CMS may request this form as part of your DCE's monitoring activities.

[1] Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK235604/. To be revised.

Centers for Medicare & Medicaid Services

CMS Target Life Cycle (TLC)

CMMI Fee-For-Service (FFS) Shared System Maintainer (SSM) and the Accountable Care Organization – Operational System (ACO-OS) Interface Control Document (ICD)

Version 8.4

06/02/2020

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Notice: This document, when a PDF, has been tested and is accessible with JAWS 11.0 or higher.

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1 Introduction

The Accountable Care Organization – Operational System (ACO-OS) handles the data collection and exchange required to manage the Next Generation Accountable Care Organization (NGACO) Model, the Vermont All Payer (VT APM) Model, the Comprehensive End Stage Renal Disease Care (CEC) Model, the Direct Contracting Model, the Kidney Care Choices (KCC) Model and the Primary Care First (PCF) Model. The ACO-OS must effectively incorporate data that the Centers for Medicare & Medicaid Services (CMS) currently manage with new data the ACOs and the ESRD Care Organizations (ESCOs) produce. The system must help CMS and these organizations manage, track, and report data so that the ACOs and ESCOs (who will be referred to collectively throughout this document as Entities) understand the totality of care provided to their beneficiaries.

This Integrated Control Document (ICD) specifies interface requirements that the ACO-OS and the Fee-for-Service Shared System Maintainers (FFS SSMs) must meet. In this document, the phrase “FFS SSMs” refers to the following Shared Systems: Common Working File (CWF) Application, Fiscal Intermediary Shared System (FISS), and Multi-Carrier System (MCS). This ICD describes the interface concept of operations (ConOps), defines the message structure and protocols that govern data interchange, and identifies the communication paths along which data are expected to flow.

1.1 Purpose

This ICD describes the relationship between the ACO-OS and the Medicare FFS SSMs for Provider and Beneficiary information as it relates to NGACO, VT APM, CEC, Direct Contracting, KCC, and PCF Models.

1.2 Project Overview

The Center for Medicare & Medicaid Innovation (CMMI) has developed the Medicare NGACO Model as one of the next-generation provider-based ACO models. The NGACO Model and VT APM operate in the traditional FFS Medicare program and maintains key aspects of the Medicare Shared Savings Program and former Pioneer Demonstration, and includes new design elements to test whether greater financial risk, more predictable financial targets and payment, benefit enhancements, and a focus on beneficiary engagement can collectively accelerate and sustain improvement in healthcare value.

The CEC Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with ESRD. Through the CEC Model, CMS will partner with health care providers and suppliers to test the effectiveness of a new payment and service delivery model in providing beneficiaries with person-centered, high-quality care. The CEC Model will implement design elements with implications for the FFS system that includes benefit enhancements to give Entities the tools to direct care and engage beneficiaries in their own care. The model also offers increased monitoring to account for different financial incentives and the provision of enhanced benefits.

KCC is designed to help health care providers reduce the cost and improve the quality of care for patients with late-stage chronic kidney disease and ESRD. This Model also aims to delay the need for dialysis and encourage kidney transplantation.

KCC has two pathways namely Kidney Care First (KCF) and Comprehensive Kidney Care Contracting (CKCC) based on the provider participation.

1. KCF is a pathway available for Entities comprising of Medicare enrolled participants who must only be nephrology practices and their nephrologists.
2. CKCC is a pathway available for Entities comprising of nephrologists, transplant providers, and other kidney care providers - including dialysis facilities. In this pathway, entities are not enrolled in Medicare.

The payment model options available under Direct Contracting aim to reduce expenditures while preserving or enhancing quality of care for beneficiaries. By aligning financial incentives, providing a prospectively determined and predictable revenue stream for participants, and putting a greater emphasis on beneficiary choice, the payment model option aims to transform risk-sharing arrangements in Medicare FFS, broaden participation in CMS Innovation Center (IC) models, empower beneficiaries, and reduce provider burden.

PCF is designed for primary care practices with advanced primary care capabilities, including those that specialize in caring for complex, chronically ill patient populations, that are prepared to accept increased financial risk in exchange for greater flexibility and potential rewards based on practice performance. This model is also designed to include practices that specialize in caring for high need, serious illness populations.

Practices under Primary Care First can choose from three participation options:

1. Practices choose to participate only in the PCF-General component of Primary Care First, and not in the Seriously Ill Population (SIP) component, i.e. “PCF-General practices”
2. Practices choose to participate only in the SIP component of Primary Care First, and not in the PCF-General component, i.e. “SIP-only practices”
3. Practices choose to participate in both the SIP and PCF-General components of Primary Care First, i.e. “hybrid practices.”

The PCF payment structure offers two different payment methodologies:

1. Total Primary Care Payment (TPCP) – Utilizes a professional Population-Based Payment (professional PBP), paid on a quarterly basis or a flat fee for each primary care visit, paid on a claim-by-claim basis.
2. Performance-Based Adjustment (PBA) – Based on quality and patient performance measures and paid on a quarterly basis.

This ICD provides the following information:

- A general interface description
- Assumptions, where appropriate
- A description of the data exchange format and exchange protocol
- Estimated data exchange size and frequency

2 ICD Overview

The ACO-OS sends the NGACO Beneficiary file with the following information to the Common Working Files (CWF) at the CWF HP Host:

- NGACO Beneficiary File Header
- NGACO Beneficiary Record Detail
- NGACO Beneficiary File Trailer

The ACO-OS sends the VT APM Beneficiary file with the following information to the Common Working Files (CWF) at the CWF HP Host:

- VT APM Beneficiary File Header
- VT APM Beneficiary Record Detail
- VT APM Beneficiary File Trailer

The ACO-OS sends the Part A/Part B NGACO/VT APM Provider file with the following information to the Multi-Carrier System (MCS) at the Hewlett Packard (HP) Virtual Data Center (VDC):

- Part A/Part B NGACO/VT APM Provider File Header
- Part A/Part B NGACO/VT APM Provider Record Detail
- Part A/Part B NGACO/VT APM Provider File Trailer

ACO-OS receives the NGACO Beneficiary Response file with the following information from the CWF:

- NGACO Beneficiary Response File Header
- NGACO Beneficiary Response Record Detail
- NGACO Beneficiary Response File Trailer

ACO-OS receives the VT APM Beneficiary Response file with the following information from the CWF:

- VT APM Beneficiary Response File Header
- VT APM Beneficiary Response Record Detail
- VT APM Beneficiary Response File Trailer

ACO-OS receives the Part A/Part B NGACO/VT APM Provider Response file with the following information from the MCS:

- Part A/Part B NGACO/VT APM Provider Response File Header
- Part A/Part B NGACO/VT APM Provider Response Record Detail
- Part A/Part B NGACO/VT APM Provider Response File Trailer

ACO-OS receives the following pass-through file from CWF for NGACO and VT APM. The details on the pass-through file are provided in Appendix B.

- Weekly All-Inclusive Population Based Payment (AIPBP) Reduction File

ACO-OS will receive the following pass-through file from CWF for Direct Contracting from 01/01/2021 onward. The details on the pass-through file are provided in Appendix C.

- Weekly Advanced Payment Option (APO)/Total Care Capitation (TCC)/Primary Care Capitation (PCC) Reduction File

ACO-OS will receive the following pass-through file from CWF for CKCC from 01/01/2021 onward. The details on the pass-through file are provided in Appendix D.

- Weekly TCC/Quarterly Capitation Payment (QCP) Reduction File

ACO-OS will receive the following pass-through file from CWF for KCC from 01/01/2021 onward. The details on the pass-through file are provided in Appendix E.

- Weekly QCP Reduction File

ACO-OS sends the CEC Beneficiary file with the following information to the CWF at the CWF HP Host:

- CEC Beneficiary File Header
- CEC Beneficiary Record Detail
- CCE Beneficiary File Trailer

ACO-OS sends the CEC Participant file with the following information to the MCS at the HP VDC:

- CEC Participant File Header
- CEC Participant Record Detail
- CEC Participant File Trailer

ACO-OS receives the CEC Beneficiary Response file with the following information from the CWF:

- CEC Beneficiary Response File Header
- CEC Beneficiary Response Record Detail
- CEC Beneficiary Response File Trailer

ACO-OS receives the CEC Participant Response file with the following information from the MCS:

- CEC Participant Response File Header
- CEC Participant Response Record Detail
- CEC Participant Response File Trailer

The ACO-OS sends the CKCC Beneficiary file with the following information to the CWF at the CWF HP Host:

- CKCC Beneficiary File Header
- CKCC Beneficiary Record Detail
- CKCC Beneficiary File Trailer

The ACO-OS sends the KCF Beneficiary file with the following information to the CWF at the CWF HP Host:

- KCF Beneficiary File Header
- KCF Beneficiary Record Detail
- KCF Beneficiary File Trailer

The ACO-OS sends the Direct Contracting Beneficiary file with the following information to the CWF at the CWF HP Host:

- Direct Contracting Beneficiary File Header
- Direct Contracting Beneficiary Record Detail
- Direct Contracting Beneficiary File Trailer

The ACO-OS sends the PCF Beneficiary file with the following information to the CWF at the CWF HP Host:

- PCF Beneficiary File Header
- PCF Beneficiary Record Detail
- PCF Beneficiary File Trailer

The ACO-OS sends the Part A/Part B CKCC/KCF Provider file with the following information to the MCS at the HP VDC:

- Part A/Part B CKCC/KCF Provider File Header
- Part A/Part B CKCC/KCF Provider Record Detail
- Part A/Part B CKCC/KCF Provider File Trailer

The ACO-OS sends the Part A/Part B Direct Contracting Provider file with the following information to the MCS at the HP VDC:

- Part A/Part B Direct Contracting Provider File Header
- Part A/Part B Direct Contracting Provider Record Detail
- Part A/Part B Direct Contracting Provider File Trailer

The ACO-OS sends the Part B PCF Provider file with the following information to the MCS at the HP VDC:

- Part B PCF Provider File Header
- Part B PCF Provider Record Detail
- Part B PCF Provider File Trailer

ACO-OS sends the CKCC/KCF Participant file with the following information to the MCS at the Companion Data Services (CDS):

- CKCC/KCF Participant File Header
- CKCC/KCF Participant Record Detail
- CKCC/KCF Participant File Trailer

ACO-OS sends the Direct Contracting Participant file with the following information to the MCS at the CDS:

- Direct Contracting Participant File Header

- Direct Contracting Participant Record Detail
- Direct Contracting Participant File Trailer

ACO-OS sends the PCF Participant file with the following information to the MCS at the CDS:

- PCF Participant File Header
- PCF Participant Record Detail
- PCF Participant File Trailer

ACO-OS receives the CKCC Beneficiary Response file with the following information from the CWF:

- CKCC Beneficiary Response File Header
- CKCC Beneficiary Response Record Detail
- CKCC Beneficiary Response File Trailer

ACO-OS receives the KCF Beneficiary Response file with the following information from the CWF:

- KCF Beneficiary Response File Header
- KCF Beneficiary Response Record Detail
- KCF Beneficiary Response File Trailer

ACO-OS receives the Direct Contracting Beneficiary Response file with the following information from the CWF:

- Direct Contracting Beneficiary Response File Header
- Direct Contracting Beneficiary Response Record Detail
- Direct Contracting Beneficiary Response File Trailer

ACO-OS receives the PCF Beneficiary Response file with the following information from the CWF:

- PCF Beneficiary Response File Header
- PCF Beneficiary Response Record Detail
- PCF Beneficiary Response File Trailer

ACO-OS receives the CKCC/KCF Participant Response file with the following information from the MCS:

- CKCC/KCF Participant Response File Header
- CKCC/KCF Participant Response Record Detail
- CKCC/KCF Participant Response File Trailer

ACO-OS receives the Direct Contracting Participant Response file with the following information from the MCS:

- Direct Contracting Participant Response File Header
- Direct Contracting Participant Response Record Detail
- Direct Contracting Participant Response File Trailer

ACO-OS receives the PCF Participant Response file with the following information from the MCS:

- PCF Participant Response File Header
- PCF Participant Response Record Detail
- PCF Participant Response File Trailer

3 Assumptions, Constraints, and Risks

This section describes assumptions, constraints, and risks associated with the interface.

3.1 Assumptions

The following assumption applies to the project:

The ACO-OS delivers the data to the FFS SSMs with specified message formatting (or record layouts) and required protocols as per the agreed Interface Initiation.

3.2 Constraints

Operational success depends on the availability and quality of data from the ACO-OS to the FFS SSMs.

3.3 Risks

The following risk may impact achievement of project performance goals:

Changes to the baseline requirement/data file layout will impact the timely implementation of this interface.

4 General Interface Requirements

This section describes general interface requirements.

4.1 Interface Overview

1. The ACO-OS sends the Part A/Part B NGACO/VT APM Provider file to the MCS at the HP VDC. The MCS sends the Part A/Part B NGACO/VT APM Provider Response file back to the ACO-OS.
2. The ACO-OS sends the NGACO Beneficiary file to the CWF at the CWF HP Host. The CWF sends the NGACO Beneficiary Response file back to the ACO-OS.
3. The ACO-OS sends the VT APM Beneficiary file to the CWF at the CWF HP Host. The CWF sends the VT APM Beneficiary Response file back to the ACO-OS.
4. The ACO-OS sends will send Direct Contracting Beneficiary file to the CWF at the CWF HP Host. The CWF sends the Direct Contracting Beneficiary Response file back to the ACO-OS.
5. The ACO-OS sends the CKCC Beneficiary file to the CWF at the CWF HP Host. The CWF sends the CKCC Beneficiary Response file back to the ACO-OS.
6. The ACO-OS sends the KCF Beneficiary file to the CWF at the CWF HP Host. The CWF sends the KCF Beneficiary Response file back to the ACO-OS.

7. The ACO-OS sends the PCF Beneficiary file to the CWF at the CWF HP Host. The CWF sends the PCF Beneficiary Response file back to the ACO-OS.
8. The ACO-OS sends the Weekly AIPBP Reduction file (pass-through file) received from CWF to Entities via the Receipt and Control System (RACS) for the NGACO, VT APM, and Direct Contracting models. These files are sent through the Electronic File Transfer (EFT) platform and are available to Entities through Entity-specific mailboxes. (For the purposes of communicating with Entities, EFT is referred to as Managed File Transfer [MFT].) These files will contain all new AIPBP claims processed information during the week for any aligned beneficiary.
9. The ACO-OS will also store these weekly files for the system of record and redistribute them to the Entities upon request.
10. The ACO-OS sends the CEC Beneficiary file to the CWF at CWF HP Host. The CWF sends the CEC Beneficiary Response file back to the ACO-OS.
11. The ACO-OS sends the CEC Participant file to the MCS at HP VDC. The MCS sends the CEC Participant Response file back to the ACO-OS.

4.2 Functional Allocation

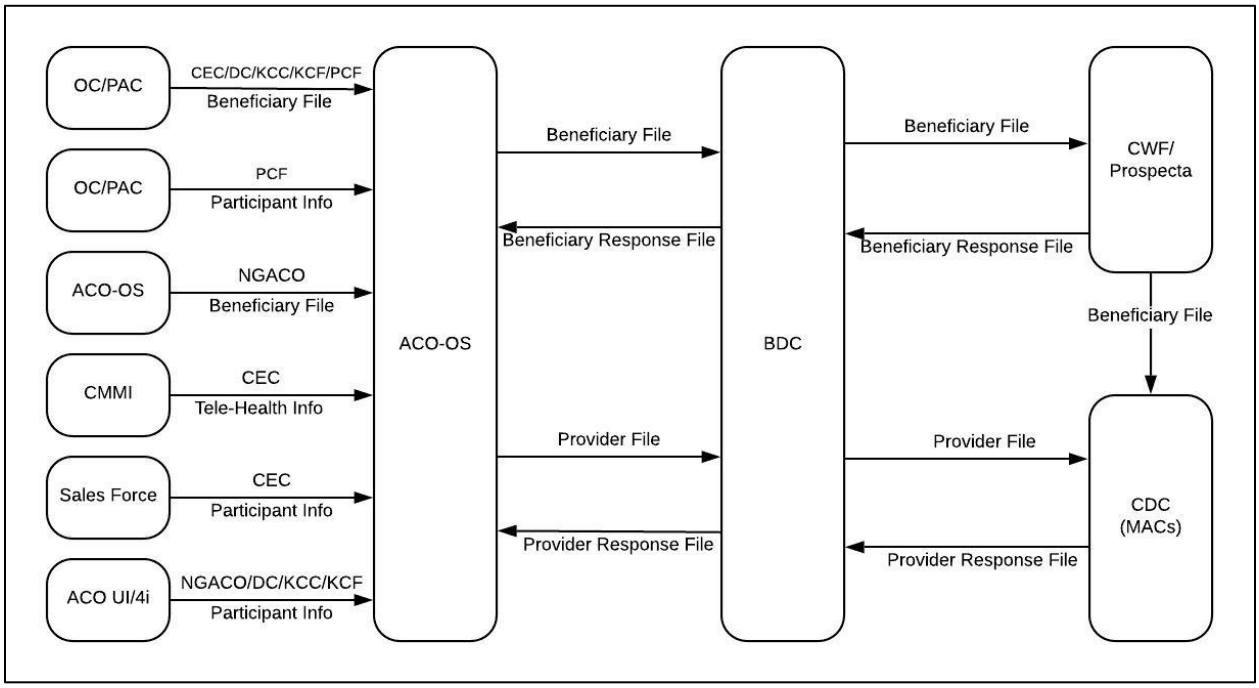
1. Based on Part A/Part B NGACO/VT APM Provider, NGACO Beneficiary information, and VT APM Beneficiary information maintained within the ACO-OS, the ACO-OS creates the following and sends the files to FFS SSMs:
    - Part A/Part B NGACO/VT APM Provider file
    - NGACO Beneficiary file
    - VT APM Beneficiary file
2. Based on CEC Participant and CEC Beneficiary information maintained within the ACO-OS, the ACO-OS creates the following and sends the files to FFS SSMs:
    - CEC Participant file
    - CEC Beneficiary file
3. Based on CKCC/KCF Participant and CKCC/KCF Beneficiary information maintained within the ACO-OS, the ACO-OS creates the following and sends the files to FFS SSMs:
    - CKCC/KCF Participant file
    - CKCC Beneficiary file
    - KCF Beneficiary file
4. Based on Direct Contracting Participant and Direct Contracting Beneficiary information maintained within the ACO-OS, the ACO-OS creates the following and sends the files to FFS SSMs:
    - Direct Contracting Participant file
    - Direct Contracting Beneficiary file
5. Based on PCF Participant and PCF Beneficiary information maintained within the ACO-OS, the ACO-OS creates the following and sends the files to FFS SSMs:
    - PCF Participant file

- PCF Beneficiary file

4.3 Data Transfer

The diagrams in the figures below display the data flow for the ACO-OS to FFS SSMs file transfers.

Figure 1: NGACO/VT APM /CKCC/KCF/Direct Contracting/PCF FFS SSM Data Flow



4.4 Transactions

1. The ACO-OS sends the following files to the CWF at the CWF HP Host:
   - NGACO Beneficiary file
   - VT APM Beneficiary file
   - CKCC Beneficiary file
   - KCF Beneficiary file
   - Direct Contracting Beneficiary file
   - PCF Beneficiary file
2. The ACO-OS sends the following file to the MCS at the HP VDC:
   - Part A/Part B NGACO/VT APM Provider file
   - Part A/Part B CKCC/KCF Provider file
   - Part A/Part B Direct Contracting Provider file
   - Part B PCF Provider file
3. The MCS sends a response file back to the ACO-OS for the Part A/Part B NGACO/VT APM Provider file received from the ACO-OS.

4. The CWF sends a response file back to the ACO-OS for the NGACO Beneficiary file received from the ACO-OS.
5. The CWF sends a response file back to the ACO-OS for the VT APM Beneficiary file received from the ACO-OS.
6. The CWF sends a response file back to the ACO-OS for the CKCC Beneficiary file received from the ACO-OS.
7. The CWF sends a response file back to the ACO-OS for the KCF Beneficiary file received from the ACO-OS.
8. The CWF sends a response file back to the ACO-OS for the Direct Contracting Beneficiary file received from the ACO-OS.
9. The CWF sends a response file back to the ACO-OS for the PCF Beneficiary file received from the ACO-OS.
10. If there are any errors identified on the Part A/Part B NGACO/VT APM/CKCC/KCF/Direct Contracting/PCF Provider Response file, the ACO-OS sends a full refresh Part A/Part B NGACO/VT APM/CKCC/ KCF/Direct Contracting/PCF Provider file back to the MCS at the HP VDC.
11. If there are any errors identified on the NGACO Beneficiary Response file, the ACO-OS sends a full refresh NGACO Beneficiary file back to the CWF at the CWF HP Host.
12. If there are any errors identified on the VT APM Beneficiary Response file, the ACO-OS sends a full refresh VT APM Beneficiary file back to the CWF at the CWF HP Host.
13. If there are any errors identified on the CKCC Beneficiary Response file, the ACO-OS sends a full refresh CKCC Beneficiary file back to the CWF at the CWF HP Host.
14. If there are any errors identified on the KCF Beneficiary Response file, the ACO-OS sends a full refresh KCF Beneficiary file back to the CWF at the CWF HP Host.
15. If there are any errors identified on the Direct Contracting Beneficiary Response file, the ACO-OS sends a full refresh Direct Contracting Beneficiary file back to the CWF at the CWF HP Host.
16. If there are any errors identified on the PCF Beneficiary Response file, the ACO-OS sends a full refresh PCF Beneficiary file back to the CWF at the CWF HP Host.
17. The ACO-OS sends the Weekly AIPBP Reduction File (pass-through file) received from CWF to Entities via RACS (specified in Appendix B). RACS logs the receipt of the pass-through file and then forwards the pass-through file to the NGACO/VT APM/CCKC/KCF/Direct Contracting Entities. The ACO-OS also stores these files for the system of record.
18. The ACO-OS sends the following file to the CWF at the CWF HP Host:
    - CEC Beneficiary file
19. The ACO-OS sends the following file to the MCS at the HP VDC:
    - CEC Participant file
20. The MCS sends a response file back to the ACO-OS for the CEC Participant file received from the ACO-OS.
21. The CWF sends a response file back to the ACO-OS for the CEC Beneficiary file received from the ACO-OS.

22. If there are any errors identified on the CEC Participant Response file, the ACO-OS sends a full refresh CEC Participant file back to the MCS at the HP VDC.
23. If there are any errors identified on the CEC Beneficiary Response file, the ACO-OS sends a full refresh CEC Beneficiary file back to the CWF at the CWF HP Host.

4.5 Security and Integrity

Files are transmitted using the CMS EFT process over a secure connection.

5 Detailed Interface Requirements

This section describes detailed interface requirements.

5.1 NGACO Beneficiary File for FFS SSMs

This section describes the information exchange between the ACO-OS and the CWF for the NGACO Beneficiary file.

5.1.1 General Processing

The ACO-OS sends the NGACO Beneficiary file to the CWF at the CWF HP Host. The CWF then sends the NGACO Beneficiary Response file to the ACO-OS.

5.1.2 Interface Processing Time Requirements

The NGACO Beneficiary data from the ACO-OS will routinely be sent monthly but could be sent more frequently if Business needs require. A full refresh file will be sent even if there is no change to the Beneficiary data. This full refresh file contains the NGACO Beneficiary data from 01/01/2016 onward.

The ACO-OS will include the most current Health Insurance Claim Number (HICN) and/or Railroad Retirement Board (RRB) Numbers associated with the beneficiary in NGACO Beneficiary file. The Delete Flag is available as of the ACO-OS December 2015 release for the excluded Beneficiaries based on program precedence exclusion.

5.1.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.1.4 File Layout

Each ACO-OS provided NGACO Beneficiary file and the corresponding CWF NGACO Beneficiary Response file has a header, record details, and trailer as described in section 5.1.4.2.

5.1.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.1.4.2.

5.1.4.2 Field/Element Definitions

All tables briefly describe a NGACO Beneficiary file transaction from the ACO-OS and a response from the CWF. The description column describes the basic file elements. The response file contains exact field values provided by the ACO-OS with the addition of a response code.

Table 1: NGACO Beneficiary File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the NGACO Beneficiary file	1	7	CHAR	HDR_BEN
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	40	CHAR	Blanks

Table 2: NGACO Beneficiary Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the NGACO Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	38	CHAR	As provided by the ACO-OS

Table 3: ACO-OS to NGACO Beneficiary Record Detail

Data Fields marked with an [I] contain Personally Identifiable Information (PII).

Data Fields marked with an [H] contain Protected Health Information (PHI).

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the NGACO Beneficiary file	1	7	CHAR	DTL_BEN
NGACO ACO Organization Identifier	Unique identifier for NGACO ACO	8	10	CHAR	V<nnn>
Delete Flag	Beneficiary who never should have been aligned, thus removed from the NGACO alignment	18	1	CHAR	'D' or Blank
Beneficiary HICN/ Beneficiary RRB# [I] [H]	Beneficiary HICN/Beneficiary External RRB Number	19	12	CHAR	Alphanumeric characters
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with the NGACO ACO	31	8	CHAR	CCYYMMDD
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a NGACO ACO	39	8	CHAR	CCYYMMDD
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	47	1	CHAR	B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Gender	Beneficiary gender	48	1	CHAR	M – Male F – Female U – Unknown
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	49	1	CHAR	Y = Yes N = No
Filler		50	6	CHAR	Blanks

Table 4: FFS SSM to ACO-OS NGACO Beneficiary Response Record Detail

Data Fields marked with an I contain PII.

Data Fields marked with an H contain PHI.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the NGACO Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processed successfully or not	8	2	NUM	As applicable
NGACO Organization Identifier	Unique identifier for NGACO ACO	10	10	CHAR	As provided by the ACO-OS
Delete Flag	Beneficiary who never should have been aligned, thus removed from the NGACO alignment	20	1	CHAR	As provided by the ACO-OS
Beneficiary HICN/ Beneficiary RRB# I H	Beneficiary HICN/Beneficiary External RRB Number	21	12	CHAR	As provided by the ACO-OS
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with an NGACO ACO	33	8	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Effective End Date	Effective end date of the beneficiary's association with an NGACO ACO	41	8	CHAR	As provided by the ACO-OS
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	49	1	CHAR	As provided by the ACO-OS
Beneficiary Gender	Beneficiary gender	50	1	CHAR	As provided by the ACO-OS
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	51	1	CHAR	As provided by the ACO-OS
Filler		52	4	CHAR	As provided by the ACO-OS

Table 5: NGACO Beneficiary File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the NGACO Beneficiary file	1	7	CHAR	TRL_BEN
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent by the ACO-OS	16	10	NUM	Numbers
Filler		26	30	CHAR	Blanks

Table 6: NGACO Beneficiary Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the NGACO Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date when the file was created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of rows or records sent by the ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	28	CHAR	As provided by the ACO-OS

5.1.4.3 Filenames

The NGACO Beneficiary file naming convention for the file sent by the ACO-OS to the CWF at the CWF HP Host will be **P#EFT.ON.CWFHP.BENE.Dyymmdd.Thhmmsst**. For example, an outbound file for December 15, 2019, at 10:00 AM would be:

P#EFT.ON.CWFHP.BENE.D191215.T1000000.

The file naming convention for the NGACO Beneficiary Response file sent by the CWF to the ACO-OS will be **P#EFT.ON.ACOT.BENE.CWFHP.Dyymmdd.Thhmmsst**. For example, an inbound file from the CWF corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.BENE.CWFHP.D191215.T1000000.

5.1.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.1.5.1 Interface Initiation

The ACO-OS sends full refresh NGACO Beneficiary file to the CWF at the CWF HP Host on each month and as needed by CMS/CMMI.

5.1.5.2 Flow Control

The ACO-OS NGACO Beneficiary files are transferred to the CWF at the CWF HP Host using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.1.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.2 VT APM Beneficiary File for FFS SSMs

This section describes the information exchange between the ACO-OS and the CWF for the VT APM Beneficiary file.

5.2.1 General Processing

The ACO-OS sends the VT APM Beneficiary file to the CWF at the CWF HP Host. The CWF then sends the VT APM Beneficiary Response file to the ACO-OS.

5.2.2 Interface Processing Time Requirements

The VT APM Beneficiary data from the ACO-OS will routinely be sent monthly but could be sent more frequently if Business needs require. A full refresh file will be sent even if there is no change to the Beneficiary data. This full refresh file contains the VT APM Beneficiary data from 01/01/2019 onward.

The ACO-OS will include the most current HICN and/or RRB Numbers associated with the beneficiary in VT APM Beneficiary file.

5.2.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.2.4 File Layout

Each ACO-OS provided VT APM Beneficiary file and the corresponding CWF VT APM Beneficiary Response file has a header, record details, and trailer as described in section 5.2.4.2.

5.2.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.2.4.2.

5.2.4.2 Field/Element Definitions

All tables briefly describe a VT APM Beneficiary file transaction from the ACO-OS and a response from the CWF. The description column describes the basic file elements. The response file contains exact field values provided by the ACO-OS with the addition of a response code.

Table 7: VT APM Beneficiary File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the VT APM Beneficiary file	1	7	CHAR	HDR_BEN
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Filler		16	40	CHAR	Blanks

Table 8: VT APM Beneficiary Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the VT APM Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	38	CHAR	As provided by the ACO-OS

Table 9: ACO-OS to VT APM Beneficiary Record Detail

Data Fields marked with an [I] contain Personally Identifiable Information (PII).

Data Fields marked with an [H] contain Protected Health Information (PHI).

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the VT APM Beneficiary file	1	7	CHAR	DTL_BEN
VT APM ACO Organization Identifier	Unique identifier for VT APM ACO	8	10	CHAR	F<nnn>
Delete Flag	Beneficiary who never should have been aligned, thus removed from the VT APM alignment	18	1	CHAR	‘D’ or Blank

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary HICN/ Beneficiary RRB# I H	Beneficiary HICN/Beneficiary External RRB Number	19	12	CHAR	Alphanumeric characters
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with the VT APM ACO	31	8	CHAR	CCYYMMDD
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a VT APM ACO	39	8	CHAR	CCYYMMDD
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	47	1	CHAR	B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific
Beneficiary Gender	Beneficiary gender	48	1	CHAR	M – Male F – Female U – Unknown
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	49	1	CHAR	Y = Yes N = No
Filler		50	6	CHAR	Blanks

Table 10: FFS SSM to ACO-OS VT APM Beneficiary Response Record Detail

Data Fields marked with an [I] contain PII.

Data Fields marked with an [H] contain PHI.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the VT APM Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processed successfully or not	8	2	NUM	As applicable
VT APM Organization Identifier	Unique identifier for VT APM ACO	10	10	CHAR	As provided by the ACO-OS
Delete Flag	Beneficiary who never should have been aligned, thus removed from the VT APM alignment	20	1	CHAR	As provided by the ACO-OS
Beneficiary HICN/ Beneficiary RRB# [I] [H]	Beneficiary HICN/Beneficiary External RRB Number	21	12	CHAR	As provided by the ACO-OS
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with an VT APM ACO	33	8	CHAR	As provided by the ACO-OS
Beneficiary Effective End Date	Effective end date of the beneficiary's association with an VT APM ACO	41	8	CHAR	As provided by the ACO-OS
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	49	1	CHAR	As provided by the ACO-OS
Beneficiary Gender	Beneficiary gender	50	1	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	51	1	CHAR	As provided by the ACO-OS
Filler		52	4	CHAR	As provided by the ACO-OS

Table 11: VT APM Beneficiary File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the VT APM Beneficiary file	1	7	CHAR	TRL_BEN
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent by the ACO-OS	16	10	NUM	Numbers
Filler		26	30	CHAR	Blanks

Table 12: VT APM Beneficiary Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the VT APM Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date when the file was created	10	8	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Detail Record Count	Number of rows or records sent by the ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	28	CHAR	As provided by the ACO-OS

5.2.4.3 Filenames

The VT APM Beneficiary file naming convention for the file sent by the ACO-OS to the CWF at the CWF HP Host will be **P#EFT.ON.CWFHP.VTBEN.Dyymmdd.Thhmmsst**. For example, an outbound file for December 15, 2019, at 10:00 AM would be:

P#EFT.ON.CWFHP.VTBEN.D191215.T1000000.

The file naming convention for the VT APM Beneficiary Response file sent by the CWF to the ACO-OS will be **P#EFT.ON.ACOT.VTBEN.CWFHP.Dyymmdd.Thhmmsst**. For example, an inbound file from the CWF corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.VTBEN.CWFHP.D191215.T1000000.

5.2.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.2.5.1 Interface Initiation

The ACO-OS sends full refresh VT APM Beneficiary file to the CWF at the CWF HP Host on each month and as needed by CMS/CMMI.

5.2.5.2 Flow Control

The ACO-OS VT APM Beneficiary files are transferred to the CWF at the CWF HP Host using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.2.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.3 Part A/Part B NGACO/VT APM Provider File for FFS SSMs

This section describes the information exchange between the ACO-OS and the MCS for the Part A/Part B NGACO/VT APM Provider File.

5.3.1 General Processing

The ACO-OS sends the Part A/Part B NGACO/VT APM Provider file to the MCS at the HP VDC. After MCS receives the Part A/Part B NGACO/VT APM Provider file from the ACO-OS, a response file is generated from the MCS along with a response code that the MCS then sends back to the ACO-OS.

5.3.2 Interface Processing Time Requirements

Part A/Part B NGACO/VT APM Provider data from the ACO-OS will be sent monthly. A full refresh file will be sent even if there is no change to the provider data. This full refresh file contains currently active and previously active benefit enhancement records for a Provider from 01/01/2016 forward for NGACO, and currently active and previously active benefit enhancement records for a Provider from 01/01/2019 for VT APM forward.

The ACO-OS will include the following Provider Types associated with an NGACO ACO on or after 01/01/2016 in the Part A/Part B NGACO/VT APM Provider File.

- Provider/Suppliers
- Preferred Providers

The ACO-OS will include the following Provider Types associated with an VT APM ACO on or after 01/01/2019 in the Part A/Part B NGACO/VT APM Provider File.

- Provider/Suppliers
- Preferred Providers

Every Provider record will have a base record accompanied by enhancement records if the provider participates in any benefit enhancements. Every enhancement will have its own record. A base record is required even when the Provider is not participating in any one of the benefit enhancements.

5.3.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.3.4 File Layout

Each ACO-OS provider file and corresponding MCS response file has a header, record details, and trailer as described in section 5.3.4.2.

5.3.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.3.4.2.

5.3.4.2 Field/Element Definitions

All tables briefly describe a file transaction from the ACO-OS and a response by the MCS. The description column describes basic file elements. The response file returns exact field values provided by the ACO-OS with the addition of a response code.

Table 13: Part A/Part B NGACO/VT APM Provider File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B NGACO/VT APM Provider file	1	7	CHAR	HDR_PRV

Data Field	Description	Start Position	Length	Format	Valid Values
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	85	CHAR	Blanks

Table 14: Part A/Part B NGACO/VT APM Provider Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B NGACO/VT APM Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	83	CHAR	As provided by the ACO-OS

Table 15: ACO-OS to Part A/Part B NGACO/VT APM Provider Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ı contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Part A/Part B NGACO/VT APM Provider file	1	7	CHAR	DTL_PRV
NGACO/VT APM Organization Identifier*	Unique identifier for NGACO/VT APM ACO	8	10	CHAR	V<nnn> F<nnn>
Provider Type*	Preferred = P Provider/Supplier = S Affiliate = A	18	1	CHAR	P S A
Participant TIN* ı	The Tax Identification Number (TIN) for the ACO Participant	19	9	NUM	Numbers
ACO Participant NPI*	The National Provider Identifier (NPI) for the ACO Participant (This field supports iNPI and oNPI)	28	10	NUM	Numbers
Participant CCN	The CMS Certification Number (CCN) for the ACO Participant	38	6	CHAR	Blank allowed

Data Field	Description	Start Position	Length	Format	Valid Values
Record Type*	Detail Record Type 0 = Base Record 1 = PBP 2 = NGACO/VTAPM TeleHealth 3 = Post Discharge Home Visit 4 = Skilled Nursing Facility (SNF) 3-Day Stay Waiver 5 = AIPBP 6 = CEC Telehealth 7 = Care Management Home Visit	44	1	CHAR	0 1 2 3 4 5 7
Participant/PBP /Enhancement Effective Start Date*	For the Base Record: Effective start date of the Provider's association with an NGACO/VT APM ACO. For PBP/AIPBP: Effective start date of the Provider utilizing PBP/AIPBP. For Benefit Enhancements: Effective start date of the Provider participating in the benefit enhancement.	45	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Provider/Enhancement Effective End Date*	For the Base Record: Effective end date of the Provider's association with an NGACO/VT APM ACO. For PBP/AIPBP: Effective end date of the Provider utilizing PBP/AIPBP. For Benefit Enhancements: Effective end date of the Provider participating in the benefit enhancement.	53	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Part A Percentage Reduction	Percentage of Part A Claims Reduction	61	3	DECIMAL	For the PBP Record: Value greater than (0) and less than (1) with two (2) implied decimals places. Ex. 0.75 will appear as 075. Value Zero is applicable for records other than PBP (or) when Part A Reduction Percentage is not available. For the AIPBP Record: Value is greater than “0” but less than or equal to (1) or 100% with two (2) implied decimal places when AIPBP is applicable. Ex. 1.00 will appear as 100. A zero value is applicable when Part A Reduction Percentage is not available.

Data Field	Description	Start Position	Length	Format	Valid Values
Part B Percentage Reduction	Percentage of Part B Claims Reduction	64	3	DECIMAL	For the PBP Record: Value greater than (0) and less than (1) with two (2) implied decimals places. Ex. 0.75 will appear as 075. Value Zero is applicable for records other than PBP (or) when Part B Reduction Percentage is not available. For the AIPBP Record: Value is greater than "0" but less than or equal to (1) or 100% with two (2) implied decimal places when AIPBP is applicable. Ex. 1.00 will appear as 100. A zero value is applicable when Part B Reduction Percentage is not available.
Filler		67	34	CHAR	Blanks

NOTES:

1. Record Type of AIPBP is not applicable for PY1.
2. Provider Type of Affiliate is not applicable for PY1.

Table 16: FFS SSM to ACO-OS Part A/Part B NGACO/VT APM Provider Response Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ǀ contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Part A/Part B NGACO/VT APM Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	As applicable
NGACO/VT APM Organization Identifier*	Unique identifier for NGACO/VT APM ACO	10	10	CHAR	As provided by the ACO-OS
Provider Type*	Preferred = P Provider/Supplier = S Affiliate = A	20	1	CHAR	As provided by the ACO-OS
Participant TIN* ǀ	The Tax Identification Number (TIN) for the ACO Participant	21	9	NUM	As provided by the ACO-OS
ACO Participant NPI*	The NPI for the ACO Participant (This field supports iNPI and oNPI).	30	10	NUM	As provided by the ACO-OS
Participant CCN	The CCN for the ACO Participant	40	6	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Record Type*	Detail Record Type 0 = Base Record 1 = PBP 2 = NGACO/VTAPM TeleHealth 3 = Post Discharge Home Visit 4 = SNF 3-Day Stay Waiver 5 = AIPBP 6 = CEC Telehealth 7 = Care Management Home Visit	46	1	CHAR	As provided by the ACO-OS
Participant/PBP /Enhancement Effective Start Date*	For the Base Record: Effective start date of the Provider's association with an NGACO/VT APM ACO. For PBP/AIPBP: Effective start date of the Provider utilizing PBP/AIPBP. For Benefit Enhancements: Effective start date of the Provider participating in the benefit enhancement.	47	8	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Provide/Enhancement Effective End Date*	For the Base Record: Effective end date of the Provider's association with an NGACO/VT APM ACO. For PBP/AIPBP: Effective end date of the Provider utilizing PBP/AIPBP. For Benefit Enhancements: Effective end date of the Provider participating in the benefit enhancement.	55	8	CHAR	As provided by the ACO-OS
Part A Percentage Reduction	Percentage of Part A Claims Reduction	63	3	DECIMAL	As provided by the ACO-OS
Part B Percentage Reduction	Percentage of Part B Claims Reduction	66	3	DECIMAL	As provided by the ACO-OS
Filler		69	32	CHAR	As provided by the ACO-OS

Table 17: Part A/Part B NGACO/VT APM Provider File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the Part A/Part B NGACO/VT APM Provider file	1	7	CHAR	TRL_PRV
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of detail rows or records sent by ACO-OS	16	10	NUM	Numbers
Filler		26	75	CHAR	Blanks

Table 18: Part A/Part B NGACO/VT APM Provider Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B NGACO/VT APM Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of detail rows or records sent by ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	73	CHAR	As provided by the ACO-OS

5.3.4.3 Filenames

The file naming convention for the Part A/Part B NGACO/VT APM Provider file sent by the ACO-OS to the MCS at the HP VDC will be **P#EFT.ON.MCSHPVDC.PRV.Dyymmdd.Thhmmsst**. For example, an outbound file for December 15, 2011, at 10:00 AM to the MCS at the HP VDC would be:

P#EFT.ON.MCSHPVDC.PRV.D111215.T1000000

The file naming convention for the Part A/Part B NGACO/VT APM Provider Response file sent by the MCS to the ACO-OS will be **P#EFT.ON.ACOT.PRV.MCSHPVDC.Dyymmdd.Thhmmsst**. For example, an inbound file from the MCS corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.PRV.MCSHPVDC.D111215.T1000000

5.3.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.3.5.1 Interface Initiation

The ACO-OS sends the Part A/Part B NGACO/VT APM Provider file to the MCS at the HP VDC.

5.3.5.2 Flow Control

The ACO-OS Part A/Part B NGACO/VT APM Provider files are transferred to the MCS at the HP VDC using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.3.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.4 CEC Beneficiary File for FFS SSMs

This section describes the information exchange between the ACO-OS and the CWF for the CEC Beneficiary file.

5.4.1 General Processing

The ACO-OS sends the CEC Beneficiary file to the CWF at the CWF HP Host. The CWF then sends the CEC Beneficiary Response file to the ACO-OS.

5.4.2 Interface Processing Time Requirements

The CEC Beneficiary file from the ACO-OS will be sent monthly but could be sent more frequently if Business needs require. ACO-OS will not send the CEC Beneficiary file if there are no updates for a month.

The CEC Beneficiary file is a full replacement file and it contains CEC Beneficiary data from 01/01/2018 forward.

ACO-OS will include the most current HICN associated with the beneficiary in the CEC Beneficiary file. The Delete Flag will include a blank; it will be available for a future release.

5.4.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.4.4 File Layout

Each ACO-OS provided CEC Beneficiary file and the corresponding CWF CEC Beneficiary Response file has a header, record details, and trailer as described in section 5.4.4.2.

5.4.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.4.4.2.

5.4.4.2 Field/Element Definitions

All tables briefly describe a CEC Beneficiary file transaction from the ACO-OS and a response from the CWF. The description column describes the basic file elements. The response file contains exact field values provided by the ACO-OS with the addition of a response code.

Table 19: CEC Beneficiary File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the CEC Beneficiary file	1	7	CHAR	HDR_BEN
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	40	CHAR	Blanks

Table 20: CEC Beneficiary Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the CEC Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	38	CHAR	As provided by the ACO-OS

Table 21: ACO-OS to CEC Beneficiary Record Detail

Data Fields marked with an [I] contain Personally Identifiable Information (PII).

Data Fields marked with an [H] contain Protected Health Information (PHI).

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the CEC Beneficiary file	1	7	CHAR	DTL_BEN
ESCO Identifier	Unique identifier for CEC ESCO	8	10	CHAR	E<nnnn>
Delete Flag	Beneficiary who never should have been aligned, thus removed from the CEC alignment	18	1	CHAR	'D' or Blanks
Beneficiary HICN/ Beneficiary RRB# [I] [H]	Beneficiary HICN/Beneficiary External RRB Number	19	12	CHAR	Alphanumeric characters
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with the CEC ESCO	31	8	CHAR	CCYYMMDD
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a CEC ESCO	39	8	CHAR	CCYYMMDD
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	47	1	CHAR	B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific Blanks

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Gender	Beneficiary gender	48	1	CHAR	M – Male F – Female U – Unknown
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	49	1	CHAR	Y = Yes N = No
Filler		50	6	CHAR	Blanks

Table 22: FFS SSM to ACO-OS CEC Beneficiary Response Record Detail

Data Fields marked with an I contain PII.

Data Fields marked with an H contain PHI.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the CEC Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processed successfully or not	8	2	NUM	As Applicable
ESCO Identifier	Unique identifier for CEC ESCO	10	10	CHAR	As provided by the ACO-OS
Delete Flag	Beneficiary who never should have been aligned, thus removed from the CEC alignment	20	1	CHAR	As provided by the ACO-OS
Beneficiary HICN/ Beneficiary RRB# I H	Beneficiary HICN/Beneficiary External RRB Number	21	12	CHAR	As provided by the ACO-OS
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with an CEC ESCO	33	8	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Effective End Date	Effective end date of the beneficiary's association with an CEC ESCO	41	8	CHAR	As provided by the ACO-OS
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	49	1	CHAR	As provided by the ACO-OS
Beneficiary Gender	Beneficiary gender	50	1	CHAR	As provided by the ACO-OS
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	51	1	CHAR	As provided by the ACO-OS
Filler		52	4	CHAR	As provided by the ACO-OS

Table 23: CEC Beneficiary File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the CEC Beneficiary file	1	7	CHAR	TRL_BEN
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent by the ACO-OS	16	10	NUM	Numbers
Filler		26	30	CHAR	Blanks

Table 24: CEC Beneficiary Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the CEC Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date when the file was created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of rows or records sent by the ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	28	CHAR	As provided by the ACO-OS

5.4.4.3 Filenames

The CEC Beneficiary file naming convention for the file sent by the ACO-OS to the CWF at the CWF HP Host will be **P#EFT.ON.CWFHP.CECBEN.Dyymmdd.Thhmmsst**. For example, an outbound file for December 15, 2011, at 10:00 AM would be:

P#EFT.ON.CWFHP.CECBEN.D111215.T1000000.

The file naming convention for the CEC Beneficiary Response file sent by the CWF to the ACO-OS will be

P#EFT.ON.ACOT.CWFHP.CBNR.Dyymmdd.Thhmmsst.

For example, an inbound file from the CWF corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.CWFHP.CBNR.D111215.T1000000.

5.4.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.4.5.1 Interface Initiation

The ACO-OS sends full replacement CEC Beneficiary file to the CWF at the CWF HP Host on each month and as needed by CMS/CMMI.

5.4.5.2 Flow Control

The ACO-OS CEC Beneficiary files are transferred to the CWF at the CWF HP Host using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling

mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.4.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.5 CEC Participant File for FFS SSMs

This section describes the information exchange between the ACO-OS and the MCS for the CEC Participant File.

5.5.1 General Processing

The ACO-OS sends the CEC Participant file to the MCS at the HP VDC. After MCS receives the CEC Participant file from the ACO-OS, a response file is generated from the MCS along with a response code that the MCS then sends back to the ACO-OS.

5.5.2 Interface Processing Time Requirements

CEC Participant data from the ACO-OS will be sent monthly. ACO-OS will not send CEC Participant file if there are no updates for a month. The CEC Participant file is a full replacement file and it contains CEC Participant data from 01/01/2018 forward.

5.5.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.5.4 File Layout

Each ACO-OS CEC Participant file and corresponding MCS response file has a header, record details, and trailer as described in section 5.5.4.2.

5.5.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.5.4.2.

5.5.4.2 Field/Element Definitions

All tables briefly describe a file transaction from the ACO-OS and a response by the MCS. The description column describes basic file elements. The response file returns exact field values provided by the ACO-OS with the addition of a response code.

Table 25: CEC Participant File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the CEC Participant file	1	7	CHAR	HDR_PRV
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	85	CHAR	Blanks

Table 26: CEC Participant Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the CEC Participant file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	83	CHAR	As provided by the ACO-OS

Table 27: ACO-OS to CEC Participant Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ǀ contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the CEC Participant file	1	7	CHAR	DTL_PRV
ESCO Identifier*	Unique identifier for CEC ESCO	8	10	CHAR	E<nnnn>
Provider Type*	Participant = P Provider/Supplier = S Affiliate = A	18	1	CHAR	P
Participant TIN* ǀ	The Tax Identification Number (TIN) for the ESCO Participant	19	9	NUM	Numbers

Data Field	Description	Start Position	Length	Format	Valid Values
Participant NPI*	The National Provider Identifier (NPI) for the ESCO Participant	28	10	NUM	Numbers
Participant CCN	The CMS Certification Number (CCN) for the ESCO Participant	38	6	CHAR	Blank allowed
Record Type*	Detail Record Type 0 = Base Record 1 = PBP 2 = NGACO/VT APM TeleHealth 3 = Post Discharge Home Visit 4 = SNF 3-Day Stay Waiver 5 = AIPBP 6 = CEC TeleHealth 7 = Care Management Home Visit	44	1	CHAR	0 6
Participant/TeleHealth Effective Start Date*	Effective start date of the Participant's association with a CEC ESCO (or) Effective start date of the Participant's TeleHealth participation.	45	8	CHAR	CCYYMMDD
Participant/TeleHealth Effective End Date*	Effective end date of the Participant's association with an CEC ESCO (or) Effective end date of the Participant's TeleHealth participation.	53	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Part A Percentage Reduction	Percentage of Part A Claims Reduction	61	3	DECIMAL	000
Part B Percentage Reduction	Percentage of Part B Claims Reduction	64	3	DECIMAL	000
Filler		67	34	CHAR	Blanks

Table 28: FFS SSM to ACO-OS CEC Participant Response Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ı contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the CEC Participant file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	As Applicable
ESCO Identifier*	Unique identifier for CEC ESCO	10	10	CHAR	As provided by the ACO-OS
Provider Type*	Participant = P Provider/Supplier = S Affiliate = A	20	1	CHAR	As provided by the ACO-OS
Participant TIN* ı	The Tax Identification Number (TIN) for the ESCO Participant	21	9	NUM	As provided by the ACO-OS
Participant NPI*	The NPI for the ESCO Participant	30	10	NUM	As provided by the ACO-OS
Participant CCN	The CCN for the ESCO Participant	40	6	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Record Type*	Detail Record Type 0 = Base Record 1 = PBP 2 = NGACO/VT APM TeleHealth 3 = Post Discharge Home Visit 4 = SNF 3-Day Stay Waiver 5 = AIPBP 6 = CEC TeleHealth 7 = Care Management Home Visit	46	1	CHAR	As provided by the ACO-OS
Participant/Tele Health Effective Start Date*	Effective start date of the Participant's association with a CEC ESCO (or) Effective start date of the Participant's TeleHealth participation.	47	8	CHAR	As provided by the ACO-OS
Participant/Tele Health Effective End Date*	Effective end date of the Participant's association with an CEC ESCO (or) Effective end date of the Participant's TeleHealth participation.	55	8	CHAR	As provided by the ACO-OS
Part A Percentage Reduction	Percentage of Part A Claims Reduction	63	3	DECIMAL	As provided by the ACO-OS
Part B Percentage Reduction	Percentage of Part B Claims Reduction	66	3	DECIMAL	As provided by the ACO-OS
Filler		69	32	CHAR	As provided by the ACO-OS

Table 29: CEC Participant File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the CEC Participant file	1	7	CHAR	TRL_PRV
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of detail rows or records sent by ACO-OS	16	10	NUM	Numbers
Filler		26	75	CHAR	Blanks

Table 30: CEC Participant Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the CEC Participant file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of detail rows or records sent by ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	73	CHAR	As provided by the ACO-OS

5.5.4.3 Filenames

The file naming convention for the CEC Participant file sent by the ACO-OS to the MCS at the HP VDC will be **P#EFT.ON.MCSHPVDC.CECPRV.Dyymmdd.Thhmmsst**. For example, an outbound file for December 15, 2011, at 10:00 AM to the MCS at the HP VDC would be:

P#EFT.ON.MCSHPVDC.CECPRV.D111215.T1000000.

The file naming convention for the CEC Participant Response file sent by the MCS to the ACO-OS will be

P#EFT.ON.ACOT.MCSHPVDC.CPVR.Dyymmdd.Thhmmsst.

For example, an inbound file from the MCS corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.MCSHPVDC.CPVR.D111215.T1000000.

5.5.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.5.5.1 Interface Initiation

The ACO-OS sends the CEC Participant file to the MCS at the HP VDC.

5.5.5.2 Flow Control

The ACO-OS CEC Participant files are transferred to the MCS at the HP VDC using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.5.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.6 CKCC Beneficiary File for FFS SSMs

This section describes the information exchange between the ACO-OS and the CWF for the CKCC Beneficiary file.

5.6.1 General Processing

The ACO-OS sends the CKCC Beneficiary file to the CWF at the CWF HP Host. The CWF then sends the CKCC Beneficiary Response file to the ACO-OS.

5.6.2 Interface Processing Time Requirements

The CKCC Beneficiary data from the ACO-OS will routinely be sent quarterly but could be sent more frequently if Business needs require. A full refresh file will be sent even if there is no change to the Beneficiary data. This full refresh file contains CKCC Beneficiary data from 11/01/2020 forward.

The ACO-OS will include the most current HICN and/or RRB Numbers associated with the beneficiary in CKCC Beneficiary file. The Delete Flag is available in ACO-OS for the excluded Beneficiaries based on program precedence exclusion.

5.6.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.6.4 File Layout

Each ACO-OS provided CKCC Beneficiary file and the corresponding CWF CKCC Beneficiary Response file has a header, record details, and trailer as described in section 5.6.4.2.

5.6.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.6.4.2.

5.6.4.2 Field/Element Definitions

All tables briefly describe a CKCC Beneficiary file transaction from the ACO-OS and a response from the CWF. The description column describes the basic file elements. The response file contains exact field values provided by the ACO-OS with the addition of a response code.

Table 31: CKCC Beneficiary File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the CKCC Beneficiary file	1	7	CHAR	HDR_BEN
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	40	CHAR	Blanks

Table 32: CKCC Beneficiary Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the CKCC Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	38	CHAR	As provided by the ACO-OS

Table 33: ACO-OS (CKCC) to FFS SSM Beneficiary Record Detail

Data Fields marked with an [I] contain Personally Identifiable Information (PII).

Data Fields marked with an [H] contain Protected Health Information (PHI).

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the CKCC Beneficiary file	1	7	CHAR	DTL_BEN
CKCC ACO Organization Identifier	Unique identifier for CKCC Entity	8	10	CHAR	C<nnnn>
Delete Flag	Beneficiary who never should have been aligned, thus removed from the CKCC alignment	18	1	CHAR	'D' or Blank
Beneficiary HICN/ Beneficiary RRB# [I] [H]	Beneficiary HICN/Beneficiary External RRB Number	19	12	CHAR	Alphanumeric characters
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with the CKCC ACO	31	8	CHAR	CCYYMMDD
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a CKCC ACO	39	8	CHAR	CCYYMMDD 12319999 for open end date
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	47	1	CHAR	B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Gender	Beneficiary gender	48	1	CHAR	M = Male F = Female U = Unknown
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	49	1	CHAR	Y = Yes N = No
QCP Indicator	Quarterly Capitated Payment Indicator	50	1	CHAR	0 = Not Qualified for QCP payment “indicates ESRD beneficiary” 1 = Qualified for QCP payment “indicates CKD beneficiary”
Filler		51	5	CHAR	Blanks

Table 34: FFS SSM to ACO-OS (CKCC) Beneficiary Response Record Detail

Data Fields marked with an [I] contain PII.

Data Fields marked with an [H] contain PHI.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the CKCC Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processed successfully or not	8	2	NUM	As applicable
CKCC Organization Identifier	Unique identifier for CKCC ACO	10	10	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Delete Flag	Beneficiary who never should have been aligned, thus removed from the CKCC alignment	20	1	CHAR	As provided by the ACO-OS
Beneficiary HICN/ Beneficiary RRB# IH	Beneficiary HICN/Beneficiary External RRB Number	21	12	CHAR	As provided by the ACO-OS
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with an CKCC ACO	33	8	CHAR	As provided by the ACO-OS
Beneficiary Effective End Date	Effective end date of the beneficiary's association with an CKCC ACO	41	8	CHAR	As provided by the ACO-OS
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	49	1	CHAR	As provided by the ACO-OS
Beneficiary Gender	Beneficiary gender	50	1	CHAR	As provided by the ACO-OS
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	51	1	CHAR	As provided by the ACO-OS
QCP Indicator	Quarterly Capitated Payment Indicator	52	1	CHAR	As provided by the ACO-OS
Filler		53	3	CHAR	

Table 35: CKCC Beneficiary File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the CKCC Beneficiary file	1	7	CHAR	TRL_BEN

Data Field	Description	Start Position	Length	Format	Valid Values
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent by the ACO-OS	16	10	NUM	Numbers
Filler		26	30	CHAR	Blanks

Table 36: CKCC Beneficiary Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the CKCC Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date when the file was created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of rows or records sent by the ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	28	CHAR	As provided by the ACO-OS

5.6.4.3 Filenames

The CKCC Beneficiary file naming convention for the file sent by the ACO-OS to the CWF at the CWF HP Host will be **P#EFT.ON.CWFHP.CKCCBENE.Dyymmdd.Thhmmsst**. For example, an outbound file for January 4, 2021, at 10:00 AM would be:

P#EFT.ON.CWFHP.CKCCBENE.D210104.T1000000.

The file naming convention for the CKCC Beneficiary Response file sent by the CWF to the ACO-OS will be **P#EFT.ON.ACOT.CWFHP.CKCCBR.Dyymmdd.Thhmmsst**. For example, an inbound file from the CWF corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.CWFHP.CKCCBR.D210104.T1000000.

5.6.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.6.5.1 Interface Initiation

The ACO-OS sends full refresh CKCC Beneficiary file to the CWF at the CWF HP Host on each month or quarterly and as needed by CMS/CMMI.

5.6.5.2 Flow Control

The ACO-OS CKCC Beneficiary files are transferred to the CWF at the CWF HP Host using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.6.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.7 KCF Beneficiary File for FFS SSMs

This section describes the information exchange between the ACO-OS and the CWF for the KCF Beneficiary file.

5.7.1 General Processing

The ACO-OS sends the KCF Beneficiary file to the CWF at the CWF HP Host. The CWF then sends the KCF Beneficiary Response file to the ACO-OS.

5.7.2 Interface Processing Time Requirements

The KCF Beneficiary data from the ACO-OS will routinely be sent quarterly but could be sent more frequently if Business needs require. A full refresh file will be sent even if there is no change to the Beneficiary data. This full refresh file contains KCF Beneficiary data from 11/01/2020 onward.

The ACO-OS will include the most current HICN and/or RRB Numbers associated with the beneficiary in KCF Beneficiary file. The Delete Flag is available in ACO-OS for the excluded Beneficiaries based on program precedence exclusion.

5.7.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.7.4 File Layout

Each ACO-OS provided KCF Beneficiary file and the corresponding CWF KCF Beneficiary Response file has a header, record details, and trailer as described in section 5.7.4.2.

5.7.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.7.4.2.

5.7.4.2 Field/Element Definitions

All tables briefly describe a KCF Beneficiary file transaction from the ACO-OS and a response from the CWF. The description column describes the basic file elements. The response file contains exact field values provided by the ACO-OS with the addition of a response code.

Table 37: KCF Beneficiary File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the KCF Beneficiary file	1	7	CHAR	HDR_BEN
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	40	CHAR	Blanks

Table 38: KCF Beneficiary Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the KCF Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	38	CHAR	As provided by the ACO-OS

Table 39: ACO-OS (KCF) to FFS SSM Beneficiary Record Detail

Data Fields marked with an [I] contain Personally Identifiable Information (PII).

Data Fields marked with an [H] contain Protected Health Information (PHI).

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the KCF Beneficiary file	1	7	CHAR	DTL_BEN
KCF ACO Organization Identifier	Unique identifier for KCF ACO	8	10	CHAR	K<nnnn>
Delete Flag	Beneficiary who never should have been aligned, thus removed from the KCF alignment	18	1	CHAR	'D' or Blank
Beneficiary HICN/ Beneficiary RRB# [I] [H]	Beneficiary HICN/Beneficiary External RRB Number	19	12	CHAR	Alphanumeric characters
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with the KCF ACO	31	8	CHAR	CCYYMMDD
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a KCF ACO	39	8	CHAR	CCYYMMDD
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	47	1	CHAR	B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Gender	Beneficiary gender	48	1	CHAR	M = Male F = Female U = Unknown
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	49	1	CHAR	Y = Yes N = No
QCP Indicator	Quarterly Capitated Payment Indicator	50	1	CHAR	0 = Not Qualified for QCP payment “indicates ESRD beneficiary” 1 = Qualified for QCP payment “indicates CKD beneficiary”
Filler		51	5	CHAR	Blanks

Table 40: FFS SSM to ACO-OS (KCF) Beneficiary Response Record Detail

Data Fields marked with an [I] contain PII.

Data Fields marked with an [H] contain PHI.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the KCF Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processed successfully or not	8	2	NUM	As applicable
KCF Organization Identifier	Unique identifier for KCF ACO	10	10	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Delete Flag	Beneficiary who never should have been aligned, thus removed from the KCF alignment	20	1	CHAR	As provided by the ACO-OS
Beneficiary HICN/ Beneficiary RRB# [1H]	Beneficiary HICN/Beneficiary External RRB Number	21	12	CHAR	As provided by the ACO-OS
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with an KCF ACO	33	8	CHAR	As provided by the ACO-OS
Beneficiary Effective End Date	Effective end date of the beneficiary's association with an KCF ACO	41	8	CHAR	As provided by the ACO-OS
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	49	1	CHAR	As provided by the ACO-OS
Beneficiary Gender	Beneficiary gender	50	1	CHAR	As provided by the ACO-OS
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	51	1	CHAR	As provided by the ACO-OS
QCP Indicator	Quarterly Capitated Payment Indicator	52	1	CHAR	As provided by the ACO-OS
Filler		53	3	CHAR	

Table 41: KCF Beneficiary File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the KCF Beneficiary file	1	7	CHAR	TRL_BEN

Data Field	Description	Start Position	Length	Format	Valid Values
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent by the ACO-OS	16	10	NUM	Numbers
Filler		26	30	CHAR	Blanks

Table 42: KCF Beneficiary Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the KCF Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date when the file was created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of rows or records sent by the ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	28	CHAR	As provided by the ACO-OS

5.7.4.3 Filenames

The KCF Beneficiary file naming convention for the file sent by the ACO-OS to the CWF at the CWF HP Host will be **P#EFT.ON.CWFHP.KCFBENE.Dyymmdd.Thhmmsst**. For example, an outbound file for January 4, 2021, at 10:00 AM would be:

P#EFT.ON.CWFHP.KCFBENE.D210104.T1000000.

The file naming convention for the KCF Beneficiary Response file sent by the CWF to the ACO-OS will be **P#EFT.ON.ACOT.CWFHP.KCFBR.Dyymmdd.Thhmmsst**. For example, an inbound file from the CWF corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.CWFHP.KCFBR.D210104.T1000000.

5.7.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.7.5.1 Interface Initiation

The ACO-OS sends full refresh KCF Beneficiary file to the CWF at the CWF HP Host on each month or quarterly and as needed by CMS/CMMI.

5.7.5.2 Flow Control

The ACO-OS KCF Beneficiary files are transferred to the CWF at the CWF HP Host using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.7.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.8 Part A/Part B CKCC/KCF Provider File for FFS SSMs

This section describes the information exchange between the ACO-OS and the MCS for the Part A/Part B CKCC/KCF Provider File.

5.8.1 General Processing

The ACO-OS sends the Part A/Part B CKCC/KCF Provider file to the MCS at the HP VDC. After MCS receives the Part A/Part B CKCC/KCF Provider file from the ACO-OS, a response file is generated from the MCS along with a response code that the MCS then sends back to the ACO-OS.

5.8.2 Interface Processing Time Requirements

Part A/Part B CKCC/KCF Provider data from the ACO-OS will be sent monthly. A full refresh file will be sent even if there is no change to the provider data. This full refresh file contains currently active and previously active benefit enhancement records for a Provider from 11/01/2020 onward.

The ACO-OS will include the following Provider Types associated with a CKCC/KCF on or after 11/01/2020 in the Part A/Part B CKCC/KCF Provider File.

- Provider/Suppliers
- Preferred Providers

Every Provider record will have a base record accompanied by enhancement records if the provider participates in any benefit enhancements. Every enhancement will have its own record. A base record is required even when the Provider is not participating in any one of the benefit enhancements.

5.8.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.8.4 File Layout

Each ACO-OS provider file and corresponding MCS response file has a header, record details, and trailer as described in section 5.8.4.2.

5.8.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.8.4.2.

5.8.4.2 Field/Element Definitions

All tables briefly describe a file transaction from the ACO-OS and a response by the MCS. The description column describes basic file elements. The response file returns exact field values provided by the ACO-OS with the addition of a response code.

Table 43: Part A/Part B CKCC/KCF Provider File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B CKCC/KCF Provider file	1	7	CHAR	HDR_PRV
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	85	CHAR	Blanks

Table 44: Part A/Part B CKCC/KCF Provider Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B CKCC/KCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler		18	83	CHAR	As provided by the ACO-OS

Table 45: ACO-OS to Part A/Part B CKCC/KCF Provider Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ı contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Part A/Part B CKCC/KCF Provider file	1	7	CHAR	DTL_PRV
CKCC/KCF Organization Identifier*	Unique identifier for CKCC/KCF ACO	8	10	CHAR	C<nnnn> K<nnnn>
Provider Type*	Preferred = P Provider/Supplier = S Affiliate = A	18	1	CHAR	P S A
Participant TIN* ı	The Tax Identification Number (TIN) for the ACO Participant	19	9	NUM	Numbers
ACO Participant NPI*	The National Provider Identifier (NPI) for the ACO Participant (This field supports iNPI and oNPI)	28	10	NUM	Numbers
Participant CCN	The CMS Certification Number (CCN) for the ACO Participant	38	6	CHAR	Blank allowed

Data Field	Description	Start Position	Length	Format	Valid Values
Record Type*	Detail Record Type 0 = Base Record 1 = APO 2 = Telehealth 3 = Post Discharge Home Visit 4 = SNF 3-Day Stay Waiver 5 = TCC 6 = CEC Telehealth 7 = Care Management Home Visit 8 = PCC 9 = Home Health Homebound Waiver A = Diabetic Shoe Orders by Nurse Practitioners B = Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits C = Kidney Disease Education Benefit Enhancement D = SIP (Represents only the providers that can bill the G code) E = PCF (Represents all providers who can bill FVF codes) F = QCP G = Adjusted Monthly Capitated Payment (AMCP)	44	1	CHAR	**KCF BEs:** 0 = Base Record 2 = Telehealth 3 = Post Discharge Home Visits 5 = TCC B = Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits C = Kidney Disease Education Benefit Enhancement F = QCP G = AMCP *Note: QCP will only apply to nephrologists and nephrology practices and will not apply to all providers who are in CKCC.*

Data Field	Description	Start Position	Length	Format	Valid Values
					CKCC BEs: 0 = Base Record 2 = Telehealth 3 = Post-Discharge Home Visits 4 = SNF 5 = TCC 9 = Home Health Homebound Waiver B = Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits C = Kidney Disease Education F = QCPG = AMCP *Note: QCP will only apply to nephrologists and nephrology practices and will not apply to all providers who are in CKCC.*
Participant/ AMCP/QCP/ TCC Enhancement Effective Start Date*	For the Base Record: Effective start date of the Provider's association with an CKCC/KCF ACO. For AMCP/QCP/TCC: Effective start date of the Provider utilizing AMCP/QCP/TCC. For Benefit Enhancements: Effective start date of the Provider participating in the benefit enhancement.	45	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Provider/AMCP /QCP/TCC Enhancement Effective End Date*	For the Base Record: Effective end date of the Provider's association with an CKCC/KCF ACO. For AMCP/QCP/TCC: Effective end date of the Provider utilizing AMCP/QCP/TCC. For Benefit Enhancements: Effective end date of the Provider participating in the benefit enhancement.	53	8	CHAR	CCYYMMDD
Part A Percentage Reduction	Percentage of Part A Claims Reduction	61	3	DECIMAL	For the AMCP Record: Value is always 0 for both Part A Reduction Percentage and Part B Reduction Percentage (0) For the QCP Record: Value is always "100" or 100% with two (2) implied decimal places when QCP is applicable. Ex. 1.00 will appear as 100. For the TCC Record: Value is greater than "0" but less than or equal to (1) or 100% with two (2) implied decimal places when TCC is applicable. Ex. 1.00 will appear as 100.

Data Field	Description	Start Position	Length	Format	Valid Values
Part B Percentage Reduction	Percentage of Part B Claims Reduction	64	3	DECIMAL	For the AMCP Record: Value is always 0 for both Part A Reduction Percentage and Part B Reduction Percentage (0) For the QCP Record: Value is always “100” or 100% with two (2) implied decimal places when QCP is applicable. Ex. 1.00 will appear as 100. For the TCC Record: Value is greater than “0” but less than or equal to (1) or 100% with two (2) implied decimal places when TCC is applicable. Ex. 1.00 will appear as 100.
ETC_IND		67	1		0 = Not an ETC participant 1 = ETC participant
Filler		68	33	CHAR	Blanks

Table 46: FFS SSM to ACO-OS Part A/Part B CKCC/KCF Provider Response Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ǀ contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Part A/Part B CKCC/KCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	As applicable
CKCC/KCF Organization Identifier*	Unique identifier for CKCC/KCF ACO	10	10	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Provider Type*	Preferred = P Provider/Supplier = S Affiliate = A	20	1	CHAR	As provided by the ACO-OS
Participant TIN*[1]	The Tax Identification Number (TIN) for the ACO Participant	21	9	NUM	As provided by the ACO-OS
ACO Participant NPI*	The NPI for the ACO Participant (This field supports iNPI and oNPI).	30	10	NUM	As provided by the ACO-OS
Participant CCN	The CCN for the ACO Participant	40	6	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Record Type*	Detail Record Type 0 = Base Record 1 = APO 2 = Telehealth 3 = Post Discharge Home Visit 4 = SNF 3-Day Stay Waiver 5 = TCC 6 = CEC Telehealth 7 = Care Management Home Visit 8 = PCC 9 = Home Health Homebound Waiver A = Diabetic Shoe Orders by Nurse Practitioners B = Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits C = Kidney Disease Education Benefit Enhancement D = SIP (Represents only the providers who can bill the G code) E = PCF (Represents all providers who can bill FVF codes) F = QCP G = AMCP	46	1	CHAR	As provided by the ACO-OS **KCF BEs:** 0 = Base Record 2 = Asynchronous Telehealth 3 = Post Discharge Home Visits 5 = TCC B = Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits C = Kidney Disease Education Benefit Enhancement F = QCP G = AMCP *Note: QCP will only apply to nephrologists and nephrology practices and will not apply to all providers who are in CKCC.*

Data Field	Description	Start Position	Length	Format	Valid Values
					CKCC BEs: 0 = Base Record 2 = Telehealth 3 = Post-Discharge Home Visits 4 = SNF 5 = TCC (even though it is delayed to 2022) 9 = Home Health Homebound Waiver A = Home Health Services Certified by Nurse Practitioners B = Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits C = Kidney Disease Education F = QCP G = AMCP *Note: QCP will only apply to nephrologists and nephrology practices and will not apply to all providers who are in CKCC.*

Data Field	Description	Start Position	Length	Format	Valid Values
Participant/AMCP/QCP/TCC Enhancement Effective Start Date*	For the Base Record: Effective start date of the Provider's association with an CKCC/KCF ACO. For AMCP/QCP/TCC: Effective start date of the Provider utilizing AMCP/QCP/TCC. For Benefit Enhancements: Effective start date of the Provider participating in the benefit enhancement.	47	8	CHAR	As provided by the ACO-OS
Provide/AMCP/QCP/TCC Enhancement Effective End Date*	For the Base Record: Effective end date of the Provider's association with an CKCC/KCF ACO. For AMCP/QCP/TCC: Effective end date of the Provider utilizing AMCP/QCP/TCC. For Benefit Enhancements: Effective end date of the Provider participating in the benefit enhancement.	55	8	CHAR	As provided by the ACO-OS
Part A Percentage Reduction	Percentage of Part A Claims Reduction	63	3	DECIMAL	As provided by the ACO-OS
Part B Percentage Reduction	Percentage of Part B Claims Reduction	66	3	DECIMAL	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
ETC_IND		69	1		0 = Not a ETC participant 1 = ETC participant
Filler		70	31	CHAR	As provided by the ACO-OS

Table 47: Part A/Part B CKCC/KCF Provider File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the Part A/Part B CKCC/KCF Provider file	1	7	CHAR	TRL_PRV
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of detail rows or records sent by ACO-OS	16	10	NUM	Numbers
Filler		26	75	CHAR	Blanks

Table 48: Part A/Part B CKCC/KCF Provider Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B CKCC/KCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of detail rows or records sent by ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	73	CHAR	As provided by the ACO-OS

5.8.4.3 Filenames

The file naming convention for the Part A/Part B CKCC/KCF Provider file sent by the ACO-OS to the MACS at the HP VDC will be **P#EFT.ON.MCSHPVDC.KCCPRV.Dyymmdd.Thhmmsst**. For example, an outbound file for January 4, 2021, at 10:00 AM to the MACS at the HP VDC would be:

P#EFT.ON.MCSHPVDC.KCCPRV.D210104.T1000000

The file naming convention for the Part A/Part B CKCC/KCF Provider Response file sent by the MCS to the ACO-OS will be **P#EFT.ON.ACOT.MCSHPVDC.KCPR.Dyymmdd.Thhmmsst**. For example, an inbound file from the MCS corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.MCSHPVDC.KCPR.D210104.T1000000

5.8.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.8.5.1 Interface Initiation

The ACO-OS sends the Part A/Part B CKCC/KCF Provider file to the MCS at the HP VDC.

5.8.5.2 Flow Control

The ACO-OS Part A/Part B CKCC/KCF Provider files are transferred to the MCS at the HP VDC using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.8.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.9 Direct Contracting Beneficiary File for FFS SSMs

This section describes the information exchange between the ACO-OS and the CWF for the Direct Contracting Beneficiary file.

5.9.1 General Processing

The ACO-OS sends the Direct Contracting Beneficiary file to the CWF at the CWF HP Host. The CWF then sends the Direct Contracting Beneficiary Response file to the ACO-OS.

5.9.2 Interface Processing Time Requirements

The Direct Contracting Beneficiary data from the ACO-OS will routinely be sent monthly but could be sent more frequently if Business needs require. A full refresh file will be sent even if there is no change to the Beneficiary data. This full refresh file contains the Direct Contracting Beneficiary data from 11/01/2020 onward.

The ACO-OS will include the most current HICN and/or RRB Numbers associated with the beneficiary in Direct Contracting Beneficiary file.

5.9.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.9.4 File Layout

Each ACO-OS provided Direct Contracting Beneficiary file and the corresponding CWF Direct Contracting Beneficiary Response file has a header, record details, and trailer as described in section 5.9.4.2.

5.9.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.9.4.2.

5.9.4.2 Field/Element Definitions

All tables briefly describe a Direct Contracting Beneficiary file transaction from the ACO-OS and a response from the CWF. The description column describes the basic file elements. The response file contains exact field values provided by the ACO-OS with the addition of a response code.

Table 49: Direct Contracting Beneficiary File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Direct Contracting Beneficiary file	1	7	CHAR	HDR_BEN
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	40	CHAR	Blanks

Table 50: Direct Contracting Beneficiary Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Direct Contracting Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Filler		18	38	CHAR	As provided by the ACO-OS

Table 51: ACO-OS to Direct Contracting Beneficiary Record Detail

Data Fields marked with an [I] contain Personally Identifiable Information (PII).

Data Fields marked with an [H] contain Protected Health Information (PHI).

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the Direct Contracting Beneficiary file	1	7	CHAR	DTL_BEN
Direct Contracting Entity (DCE) Identifier	Unique identifier for DCE	8	10	CHAR	D<nnnn>
Delete Flag	Beneficiary who never should have been aligned, thus removed from the Direct Contracting alignment	18	1	CHAR	'D' or Blank
Beneficiary HICN/ Beneficiary RRB# [I] [H]	Beneficiary HICN/Beneficiary External RRB Number	19	12	CHAR	Alphanumeric characters
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with the DCE	31	8	CHAR	CCYYMMDD
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a DCE	39	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	47	1	CHAR	B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific
Beneficiary Gender	Beneficiary gender	48	1	CHAR	M = Male F = Female U = Unknown
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	49	1	CHAR	Y = Yes N = No
Filler		50	6	CHAR	Blanks

Table 52: FFS SSM to ACO-OS Direct Contracting Beneficiary Response Record Detail

Data Fields marked with an I contain PII.

Data Fields marked with an H contain PHI.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the Direct Contracting Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processed successfully or not	8	2	NUM	As Applicable
DCE Identifier	Unique identifier for a DCE	10	10	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Delete Flag	Beneficiary who never should have been aligned, thus removed from the Direct Contracting alignment	20	1	CHAR	As provided by the ACO-OS
Beneficiary HICN/ Beneficiary RRB# [I H]	Beneficiary HICN/Beneficiary External RRB Number	21	12	CHAR	As provided by the ACO-OS
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with a DCE	33	8	CHAR	As provided by the ACO-OS
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a DCE	41	8	CHAR	As provided by the ACO-OS
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	49	1	CHAR	As provided by the ACO-OS
Beneficiary Gender	Beneficiary gender	50	1	CHAR	As provided by the ACO-OS
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	51	1	CHAR	As provided by the ACO-OS
Filler		52	4	CHAR	As provided by the ACO-OS

Table 53: Direct Contracting Beneficiary File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the Direct Contracting Beneficiary file	1	7	CHAR	TRL_BEN

Data Field	Description	Start Position	Length	Format	Valid Values
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent by the ACO-OS	16	10	NUM	Numbers
Filler		26	30	CHAR	Blanks

Table 54: Direct Contracting Beneficiary Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the Direct Contracting Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date when the file was created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of rows or records sent by the ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	28	CHAR	As provided by the ACO-OS

5.9.4.3 Filenames

The Direct Contracting Beneficiary file naming convention for the file sent by the ACO-OS to the CWF at the CWF HP Host will be **P#EFT.ON.CWFHP.DCBENE.Dyymmdd.Thhmmsst**. For example, an outbound file for January 4, 2021, at 10:00 AM would be:

P#EFT.ON.CWFHP.DCBENE.D210104.T1000000.

The file naming convention for the Direct Contracting Beneficiary Response file sent by the CWF to the ACO-OS will be **P#EFT.ON.ACOT.CWFHP.DCBR.Dyymmdd.Thhmmsst**. For example, an inbound file from the CWF corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.CWFHP.DCBR.D210104.T1000000.

5.9.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.9.5.1 Interface Initiation

The ACO-OS sends full refresh Direct Contracting Beneficiary file to the CWF at the CWF HP Host on each month and as needed by CMS/CMMI.

5.9.5.2 Flow Control

The ACO-OS Direct Contracting Beneficiary files are transferred to the CWF at the CWF HP Host using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.9.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.10 Part A/Part B Direct Contracting Provider File for FFS SSMs

This section describes the information exchange between the ACO-OS and the MCS for the Part A/Part B Direct Contracting Provider File.

5.10.1 General Processing

The ACO-OS sends the Part A/Part B Direct Contracting Provider file to the MCS at the HP VDC. After MCS receives the Part A/Part B Direct Contracting Provider file from the ACO-OS, a response file is generated from the MCS along with a response code that the MCS then sends back to the ACO-OS.

5.10.2 Interface Processing Time Requirements

Part A/Part B Direct Contracting Provider data from the ACO-OS will be sent monthly. A full refresh file will be sent even if there is no change to the provider data. This full refresh file contains currently active and previously active benefit enhancement records for a Provider from 01/01/2021 forward for Direct Contracting records.

The ACO-OS will include the following Provider Types associated with a DCE on or after 01/01/2021 in the Part A/Part B Direct Contracting Provider File.

- Participant Providers
- Preferred Providers

Every Provider record will have a base record accompanied by enhancement records if the provider participates in any benefit enhancements. Every enhancement will have its own record. A base record is required even when the Provider is not participating in any one of the benefit enhancements.

5.10.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.10.4 File Layout

Each ACO-OS provider file and corresponding MCS response file has a header, record details, and trailer as described in section 5.10.4.2.

5.10.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.10.4.2.

5.10.4.2 Field/Element Definitions

All tables briefly describe a file transaction from the ACO-OS and a response by the MCS. The description column describes basic file elements. The response file returns exact field values provided by the ACO-OS with the addition of a response code.

Table 55: Part A/Part B Direct Contracting Provider File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B Direct Contracting Provider file	1	7	CHAR	HDR_PRV
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler		16	85	CHAR	Blanks

Table 56: Part A/Part B Direct Contracting Provider Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B Direct Contracting Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Filler		18	83	CHAR	As provided by the ACO-OS

Table 57: ACO-OS to Part A/Part B Direct Contracting Provider Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ǀ contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Part A/Part B Direct Contracting Provider file	1	7	CHAR	DTL_PRV
DCE Identifier*	Unique identifier for DCE	8	10	CHAR	D<nnnn>
Provider Type*	Preferred Provider = P Participant Provider = S Affiliate = A	18	1	CHAR	P S A
Provider TIN* ǀ	The Tax Identification Number (TIN) for the ACO Participant	19	9	NUM	Numbers
ACO Provider NPI*	The National Provider Identifier (NPI) for the ACO Provider (This field supports iNPI and oNPI)	28	10	NUM	Numbers
Provider CCN	The CMS Certification Number (CCN) for the ACO Provider	38	6	CHAR	Blank allowed

Data Field	Description	Start Position	Length	Format	Valid Values
Record Type*	Detail Record Type 0 = Base Record 1 = APO 2 = TeleHealth 3 = Post Discharge Home Visit 4 = SNF 3-Day Stay Waiver 5 = TCC 6 = CEC Telehealth 7 = Care Management Home Visit 8 = PCC 9 = Home Health Homebound Waiver A = Diabetic Shoe Orders by Nurse Practitioners B = Concurrent Care for Beneficiaries who Elect the Medicare Hospice Benefits C = Kidney Disease Education Benefit Enhancement D = SIP (Represents only the providers who can bill the G code) E = PCF (Represents all providers who can bill FVF codes) F = QCP G = AMCP	44	1	CHAR	0 1 2 3 4 5 7 8 9 B

Data Field	Description	Start Position	Length	Format	Valid Values
Provider Effective Start Date in the DCE/Benefit*	For the Base Record, the Effective Start Date is the date the Provider was first aligned to the DCE. For all other BE records, the Effective Start Date is the date the provider started the Benefit Enhancement.	45	8	CHAR	CCYYMMDD
Provider Effective End Date in the DCE/Benefit*	For the Base Record, the Effective End Date is the date the Provider was last aligned to the DCE. For all other Benefit Enhancement records, the Effective End Date is the date the provider discontinued the Benefit Enhancement.	53	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Part A Percentage Reduction	Percentage of Part A Claims Reduction	61	3	DECIMAL	For the APO Record: Value greater than (0) and less than (1) with two (2) implied decimals places. Ex. 0.75 will appear as 075. Value Zero is applicable for records other than APO (or) when Part A Reduction Percentage is not available. For the TCC/PCC Record: Value is greater than "0" but less than or equal to (1) or 100% with two (2) implied decimal places when TCC/PCC is applicable. Ex. 1.00 will appear as 100. A zero value is applicable when Part A Reduction Percentage is not available.

Data Field	Description	Start Position	Length	Format	Valid Values
Part B Percentage Reduction	Percentage of Part B Claims Reduction	64	3	DECIMAL	For the APO Record: Value greater than (0) and less than (1) with two (2) implied decimals places. Ex. 0.75 will appear as 075. Value Zero is applicable for records other than APO (or) when Part B Reduction Percentage is not available. For the TCC/PCC Record: Value is greater than "0" but less than or equal to (1) or 100% with two (2) implied decimal places when TCC/PCC is applicable. Ex. 1.00 will appear as 100. A zero value is applicable when Part B Reduction Percentage is not available.
Filler		67	34	CHAR	Blanks

NOTE:

Provider Type of Affiliate is not applicable for PY1.

Table 58: FFS SSM to ACO-OS Part A/Part B Direct Contracting Provider Response Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ǀ contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Part A/Part B Direct Contracting Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	As Applicable
DCE Identifier*	Unique identifier for Direct Contracting APM ACO	10	10	CHAR	As provided by the ACO-OS
Provider Type*	Preferred Provider = P Participant Provider = S Affiliate = A	20	1	CHAR	As provided by the ACO-OS
Provider TIN* ǀ	The Tax Identification Number (TIN) for the ACO Participant	21	9	NUM	As provided by the ACO-OS
ACO Provider NPI*	The NPI for the ACO Provider (This field supports iNPI and oNPI).	30	10	NUM	As provided by the ACO-OS
Provider CCN	The CCN for the ACO Provider	40	6	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Record Type*	Detail Record Type 0 = Base Record 1 = APO 2 = TeleHealth 3 = Post Discharge Home Visit 4 = SNF 3-Day Stay Waiver 5 = TCC 6 = CEC Telehealth 7 = Care Management Home Visit 8 = PCC 9 = Home Health Homebound Waiver A = Diabetic Shoe Orders by Nurse Practitioners B = Concurrent Care for Beneficiaries who Elect the Medicare Hospice Benefits C = Kidney Disease Education Benefit Enhancement D = SIP (Represents only the providers who can bill the G code) E = PCF (Represents all providers who can bill FVF codes) F = QCP G = AMCP	46	1	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Provider Effective Start Date in the DCE/Benefit*	For the Base Record, the Effective Start Date is the date the Provider was first aligned to the DCE. For all other Benefit Enhancement records, the Effective Start Date is the date the provider started the Benefit Enhancement.	47	8	CHAR	As provided by the ACO-OS
Provider Effective End Date in the DCE/Benefit*	For the Base Record, the Effective End Date is the date the Provider was last aligned to the DCE. For all other Benefit Enhancement records, the Effective End Date is the date the provider discontinued the Benefit Enhancement.	55	8	CHAR	As provided by the ACO-OS
Part A Percentage Reduction	Percentage of Part A Claims Reduction	63	3	DECIMAL	As provided by the ACO-OS
Part B Percentage Reduction	Percentage of Part B Claims Reduction	66	3	DECIMAL	As provided by the ACO-OS
Filler		69	32	CHAR	As provided by the ACO-OS

Table 59: Part A/Part B Direct Contracting Provider File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the Part A/Part B Direct Contracting Provider file	1	7	CHAR	TRL_PRV
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of detail rows or records sent by ACO-OS	16	10	NUM	Numbers
Filler		26	75	CHAR	Blanks

Table 60: Part A/Part B Direct Contracting Provider Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part A/Part B Direct Contracting Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of detail rows or records sent by ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler		28	73	CHAR	As provided by the ACO-OS

5.10.4.3 Filenames

The file naming convention for the Part A/Part B Direct Contracting Provider file sent by the ACO-OS to the MCS at the HP VDC will be

P#EFT.ON.MCSHPVDC.DCPRV.Dyymmdd.Thhmmsst. For example, an outbound file for January 4, 2021, at 10:00 AM to the MCS at the HP VDC would be:

P#EFT.ON.MCSHPVDC.DCPRV.D210104.T1000000.

The file naming convention for the Part A/Part B Direct Contracting Provider Response file sent by the MCS to the ACO-OS will be **P#EFT.ON.ACOT.MCSHPVDC.DCPR.Dyymmdd.Thhmmsst**. For example, an inbound file from the MCS corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.MCSHPVDC.DCPR.D210104.T1000000.

5.10.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.10.5.1 Interface Initiation

The ACO-OS sends the Part A/Part B Direct Contracting Provider file to the MCS at the HP VDC.

5.10.5.2 Flow Control

The ACO-OS Part A/Part B Direct Contracting Provider files are transferred to the MCS at the HP VDC using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.10.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.11 PCF Beneficiary File for FFS SSMs

This section describes the information exchange between the ACO-OS and the CWF for the PCF Beneficiary file.

5.11.1 General Processing

The ACO-OS sends the PCF Beneficiary file to the CWF at the CWF HP Host. The CWF then sends the PCF Beneficiary Response file to the ACO-OS.

5.11.2 Interface Processing Time Requirements

The PCF Beneficiary data from the ACO-OS will routinely be sent monthly but could be sent more frequently if Business needs require. A full refresh file will be sent even if there is no change to the Beneficiary data. This full refresh file contains the PCF Beneficiary data from 10/01/2020 onward.

The ACO-OS will include the most current HICN and/or RRB Numbers associated with the beneficiary in PCF Beneficiary file.

5.11.3 Message Format (or Record Layout) & Required Protocols

The file is fixed-length format.

5.11.4 File Layout

Each ACO-OS provided PCF Beneficiary file and the corresponding CWF PCF Beneficiary Response file has a header, record details, and trailer as described in section 5.11.4.2.

5.11.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.11.4.2.

5.11.4.2 Field/Element Definitions

All tables briefly describe a PCF Beneficiary file transaction from the ACO-OS and a response from the CWF. The description column describes the basic file elements. The response file contains exact field values provided by the ACO-OS with the addition of a response code.

Table 61: PCF Beneficiary File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the PCF file	1	7	CHAR	HDR_BEN
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler	Unused area filled with spaces.	16	40	CHAR	Blanks

Table 62: PCF Beneficiary Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the PCF Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler	Unused area filled with spaces.	18	38	CHAR	As provided by the ACO-OS

Table 63: ACO-OS to PCF Beneficiary Record Detail

Data Fields marked with an [I] contain Personally Identifiable Information (PII).

Data Fields marked with an [H] contain Protected Health Information (PHI).

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the PCF Beneficiary file, for PCF/SIP beneficiaries	1	7	CHAR	DTL_BEN Alphanumeric
PCF Model Identifier/Practice Location ID	Unique identifier for PCF Entity	8	10	CHAR	P<two character region cd><nnnn>
Delete Flag	Beneficiary who never should have been aligned, thus removed from the PCF alignment	18	1	CHAR	'D' or Blank
Beneficiary HICN [I] [H]	Beneficiary Health Insurance Claim Number (HICN)	19	12	CHAR	Alphanumeric characters Health Insurance Claim Number (only format is validated by the MCS) (Field will not contain an MBI)
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with the PCF Entity	31	8	CHAR	CCYYMMDD
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a PCF Entity	39	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	47	1	CHAR	B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific
Beneficiary Gender	Beneficiary gender	48	1	CHAR	M = Male F = Female U = Unknown
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	49	1	CHAR	Y = Yes N = No
Filler/QCP Indicator	Unused area filled with spaces.	50	1	CHAR	Blanks
Population Indicator	Indicates whether the Beneficiary is in Seriously Ill Population (SIP)	51	1	CHAR	S = SIP Population or blank
Filler	Unused area filled with spaces.	52	4	CHAR	Blanks

Table 64: FFS SSM to ACO-OS PCF Beneficiary Response Record Detail

Data Fields marked with an I contain PII.

Data Fields marked with an H contain PHI.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is record detail information for the PCF Beneficiary file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processed successfully or not	8	2	NUM	As Applicable
PCF Model Identifier/ Practice Location ID	Unique identifier for a PCF Entity	10	10	CHAR	As provided by the ACO-OS
Delete Flag	Beneficiary who never should have been aligned, thus removed from the PCF alignment	20	1	CHAR	As provided by the ACO-OS
Beneficiary HICN I H	Beneficiary Health Insurance Claim Number (HICN)	21	12	CHAR	As provided by the ACO-OS
Beneficiary Effective Start Date	Effective start date of the beneficiary's association with a PCF Entity	33	8	CHAR	As provided by the ACO-OS
Beneficiary Effective End Date	Effective end date of the beneficiary's association with a PCF Entity	41	8	CHAR	As provided by the ACO-OS
Beneficiary Host ID	Identifies the CWF location where a beneficiary's Medicare Utilization Records are maintained.	49	1	CHAR	As provided by the ACO-OS
Beneficiary Gender	Beneficiary gender	50	1	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Beneficiary Medical Data Sharing Preference Indicator	Indicates whether the Beneficiary chose to share medical data.	51	1	CHAR	As provided by the ACO-OS
Filler/QCP Indicator	Unused area filled with spaces.	52	1	CHAR	As provided by the ACO-OS
Population Indicator	Indicates whether the Beneficiary is in Seriously Ill Population (SIP)	53	1	CHAR	As provided by the ACO-OS
Filler	Unused area filled with spaces.	54	2	CHAR	Blanks

Table 65: PCF Beneficiary File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the PCF Beneficiary file	1	7	CHAR	TRL_BEN
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of rows or records sent by the ACO-OS	16	10	NUM	Numbers
Filler	Unused area filled with spaces.	26	30	CHAR	Blanks

Table 66: PCF Beneficiary Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the PCF Beneficiary file	1	7	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date when the file was created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of rows or records sent by the ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler	Unused area filled with spaces.	28	28	CHAR	As provided by the ACO-OS

5.11.4.3 Filenames

The PCF Beneficiary file naming convention for the file sent by the ACO-OS to the CWF at the CWF HP Host will be **P#EFT.ON.CWFHP.PCFBENE.Dyymmdd.Thhmmsst**. For example, an outbound file for January 4, 2021, at 10:00 AM would be:

P#EFT.ON.CWFHP.PCFBENE.D210104.T1000000.

The file naming convention for the PCF Beneficiary Response file sent by the CWF to the ACO-OS will be **P#EFT.ON.ACOT.CWFHP.PCFBR.Dyymdd.Thhmmsst**. For example, an inbound file from the CWF corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.CWFHP.PCFBR.D210104.T1000000.

5.11.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.11.5.1 Interface Initiation

The ACO-OS sends full refresh PCF Beneficiary file to the CWF at the CWF HP Host on each month and as needed by CMS/CMMI.

5.11.5.2 Flow Control

The ACO-OS PCF Beneficiary files are transferred to the CWF at the CWF HP Host using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.11.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.12 Part B PCF Provider File for FFS SSMs

This section describes the information exchange between the ACO-OS and the MCS for the Part B PCF Provider File.

5.12.1 General Processing

The ACO-OS sends the Part B PCF Provider file to the MCS at the HP VDC. After MCS receives the Part B PCF Provider file from the ACO-OS, a response file is generated from the MCS along with a response code that the MCS then sends back to the ACO-OS.

5.12.2 Interface Processing Time Requirements

Part B PCF Provider data from the ACO-OS will be sent monthly. A full refresh file will be sent even if there is no change to the provider data. This full refresh file contains currently active and previously active benefit enhancement records for a Provider from 10/01/2020 forward for PCF records.

The ACO-OS will include the following Provider Types associated with a PCF Entity by December 31, 2020 in the Part B PCF Provider File.

- Provider/Suppliers

5.12.3 Message Format (or Record Layout) & Required Protocols

All the provider records under PCF/SIP model will carry benefit enhancements and every enhancement will have its own record. A base record is not required. The file is fixed-length format.

5.12.4 File Layout

Each ACO-OS provider file and corresponding MCS response file has a header, record details, and trailer as described in section 5.12.4.2.

5.12.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.12.4.2.

5.12.4.2 Field/Element Definitions

All tables briefly describe a file transaction from the ACO-OS and a response by the MCS. The description column describes basic file elements. The response file returns exact field values provided by the ACO-OS with the addition of a response code.

Table 67: Part B PCF Provider File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part B PCF Provider file	1	7	CHAR	HDR_PRV
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Filler	Unused area filled with spaces	16	85	CHAR	Blanks

Table 68: Part B PCF Provider Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part B PCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Filler	Unused area filled with spaces	18	83	CHAR	As provided by the ACO-OS

Table 69: ACO-OS to Part B PCF Provider Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ı contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Part B PCF Provider file	1	7	CHAR	DTL_PRV
PCF Model Identifier/ Practice ID*	Unique identifier for PCF Entity	8	10	CHAR	P<two character region cd><nnnn>
Provider Type*	Preferred = P Provider/Supplier = S Affiliate = A	18	1	CHAR	S
Participant TIN* ı	TIN for the Entity Participant	19	9	NUM	Numbers
Participant NPI*	NPI for the Entity Participant (This field supports iNPI and oNPI)	28	10	NUM	Numbers
Provider CCN	CCN for the Entity Participant	38	6	CHAR	Blank allowed, For PCF this will be initialized to spaces
Record Type*	Detail Record Type A = Diabetic Shoe Order by Nurse Practitioners D = SIP (Represents only the providers who can bill the G code) E = PCF (Represents all providers who can bill FVF codes)	44	1	CHAR	A D E Note: Do not send a 0 record
Provider / Enhancement Effective Start Date*	Effective Start Date	45	8	CHAR	CCYYMMDD

Data Field	Description	Start Position	Length	Format	Valid Values
Provider/ Enhancement Effective End Date*	Effective End Date	53	8	CHAR	CCYYMMDD
Part A Percentage Reduction	Percentage of Part A Claims Reduction	61	3	DECIMAL	Will be initialized to zeros
Part B Percentage Reduction	Percentage of Part B Claims Reduction	64	3	DECIMAL	Will be initialized to zeros
Filler	Unused area filled with spaces	67	34	CHAR	Blanks

Table 70: FFS SSM to ACO-OS Part B PCF Provider Response Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an I contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the Part B PCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	As Applicable
PCF Model Identifier/ Practice ID*	Unique identifier for PCF Entity	10	10	CHAR	As provided by the ACO-OS
Provider Type*	Preferred = P Provider/Supplier = S Affiliate = A	20	1	CHAR	As provided by the ACO-OS
Provider TIN* I	TIN for the ACO Provider	21	9	NUM	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Provider NPI*	NPI for the Entity Provider (This field supports iNPI and oNPI).	30	10	NUM	As provided by the ACO-OS
Provider CCN	CCN for the Entity Provider	40	6	CHAR	As provided by the ACO-OS
Record Type*	Detail Record Type A = Diabetic Shoe Order by Nurse Practitioners D = SIP (Represents only the providers who can bill the G code) E = PCF (Represents all providers who can bill FVF codes)	46	1	CHAR	As provided by the ACO-OS
Provider / Enhancement Effective Start Date*	Effective Start Date	47	8	CHAR	As provided by the ACO-OS
Provider/ Enhancement Effective End Date*	Effective End Date	55	8	CHAR	As provided by the ACO-OS
Part A Percentage Reduction	Percentage of Part A Claims Reduction	63	3	DECIMAL	As provided by the ACO-OS
Part B Percentage Reduction	Percentage of Part B Claims Reduction	66	3	DECIMAL	As provided by the ACO-OS
Filler	Unused area filled with spaces.	69	32	CHAR	As provided by the ACO-OS

Table 71: Part B PCF Provider File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the Part B PCF Provider file	1	7	CHAR	TRL_PRV
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of detail rows or records sent by ACO-OS	16	10	NUM	Numbers
Filler	Unused area filled with spaces	26	75	CHAR	Blanks

Table 72: Part B PCF Provider Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part B PCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of detail rows or records sent by ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler	Unused area filled with spaces	28	73	CHAR	As provided by the ACO-OS

5.12.4.3 Filenames

The file naming convention for the Part B PCF Provider file sent by the ACO-OS to the MCS at the HP VDC will be **P#EFT.ON.MCSHPVDC.PCFPRV.Dyymmdd.Thhmmsst**. For example, an outbound file for January 4, 2021, at 10:00 AM to the MCS at the HP VDC would be:

P#EFT.ON.MCSHPVDC.PCFPRV.D210104.T1000000.

The file naming convention for the Part B PCF Provider Response file sent by the MCS to the ACO-OS will be **P#EFT.ON.ACOT.MCSHPVDC.PCPR.Dyymmdd.Thhmmsst**. For example, an inbound file from the MCS corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.MCSHPVDC.PCPR.D210104.T1000000.

5.12.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.12.5.1 Interface Initiation

The ACO-OS sends the Part B PCF Provider file to the MCS at the HP VDC.

5.12.5.2 Flow Control

The ACO-OS Part B PCF Provider files are transferred to the MCS at the HP VDC using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.12.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

5.13 Durable Medical Equipment (DME) (Diabetic Shoe Order by Nurse Practitioner) PCF Provider File for FFS SSMs

This section describes the information exchange between the ACO-OS and the ViPS Medicare System (VMS) for the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider File.

5.13.1 General Processing

The ACO-OS sends the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider file to the VMS. After VMS receives the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider file from the ACO-OS, a response file is generated from the VMS along with a response code that the VMS then sends back to the ACO-OS.

5.13.2 Interface Processing Time Requirements

DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider data from the ACO-OS will be sent monthly. A full refresh file will be sent even if there is no change to the provider data. This full refresh file contains currently active and previously active benefit enhancement records for a Provider.

The ACO-OS will include the following Provider Types associated with a PCF Entity by December 31, 2020 in the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider File.

- Provider/Suppliers (Participating Providers that are Nurse Practitioners)

5.13.3 Message Format (or Record Layout) & Required Protocols

All the provider records under PCF model will carry benefit enhancements and every enhancement will have its own record. A base record is not required. The file is fixed-length format.

5.13.4 File Layout

Each ACO-OS provider file and corresponding VMS response file has a header, record details, and trailer as described in section 5.13.4.2.

5.13.4.1 Data Assembly Characteristics

For data field names and format of file delivery, see section 5.12.4.2.

5.13.4.2 Field/Element Definitions

All tables briefly describe a file transaction from the ACO-OS and a response by the VMS. The description column describes basic file elements. The response file returns exact field values provided by the ACO-OS with the addition of a response code.

Table 73: DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider file	1	7	CHAR	HDR_PRV
File Creation Date	Date the file is created	8	8	CHAR	CCYYMMDD
Filler	Unused area filled with spaces	16	85	CHAR	Blanks

Table 74: DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider Response File Header

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the Part B PCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Filler	Unused area filled with spaces	18	83	CHAR	As provided by the ACO-OS

Table 75: ACO-OS to DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an [I] contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider file	1	7	CHAR	DTL_PRV
PCF Model Identifier/ Practice ID*	Unique identifier for PCF Entity	8	10	CHAR	P<two-character region cd><nnnn>
Provider Type*	Preferred = P Provider/Supplier = S (Participating Providers) Affiliate = A	18	1	CHAR	S
Participant TIN* [I]	TIN for the Entity Participant	19	9	NUM	Numbers
Participant NPI*	NPI for the Entity Participant (This field supports iNPI and oNPI)	28	10	NUM	Numbers
Provider CCN	CCN for the Entity Participant	38	6	CHAR	Blank allowed For PCF this will be initialized to spaces
Record Type*	Detail Record Type A = Diabetic Shoe Order by Nurse Practitioners	44	1	CHAR	A *Note: Do not send a 0 record*

Data Field	Description	Start Position	Length	Format	Valid Values
Provider /Enhancement Effective Start Date*	Provider Effective Start Date	45	8	CHAR	CCYYMMDD
Provider/ Enhancement Effective End Date*	Provider Effective End Date	53	8	CHAR	CCYYMMDD
Part A Percentage Reduction	Percentage of Part A Claims Reduction	61	3	DECIMAL	Will be initialized to zeros
Part B Percentage Reduction	Percentage of Part B Claims Reduction	64	3	DECIMAL	Will be initialized to zeros
Filler	Unused area filled with spaces	67	34	CHAR	Blanks

Table 76: FFS SSM (VMC) to ACO-OS DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider Response Record Detail

Data Fields marked with an asterisk (*) are required.

Data Fields marked with an ǀ contain PII.

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier*	Record indicator which identifies the line entry is record detail information for the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	As Applicable
PCF Model Identifier/ Practice ID*	Unique identifier for PCF Entity	10	10	CHAR	As provided by the ACO-OS

Data Field	Description	Start Position	Length	Format	Valid Values
Provider Type*	Preferred = P Provider/Supplier = S Affiliate = A	20	1	CHAR	As provided by the ACO-OS
Provider TIN* ǀ	TIN for the ACO Provider	21	9	NUM	As provided by the ACO-OS
Provider NPI*	NPI for the Entity Provider (This field supports iNPI and oNPI)	30	10	NUM	As provided by the ACO-OS
Provider CCN	CCN for the Entity Provider	40	6	CHAR	As provided by the ACO-OS
Record Type*	Detail Record Type A = Diabetic Shoe Order by Nurse Practitioners	46	1	CHAR	As provided by the ACO-OS
Provider /Enhancement Effective Start Date*	Provider Effective Start Date	47	8	CHAR	As provided by the ACO-OS
Provider/ Enhancement Effective End Date*	Provider Effective End Date	55	8	CHAR	As provided by the ACO-OS
Part A Percentage Reduction	Percentage of Part A Claims Reduction	63	3	DECIMAL	As provided by the ACO-OS
Part B Percentage Reduction	Percentage of Part B Claims Reduction	66	3	DECIMAL	As provided by the ACO-OS
Filler	Unused area filled with spaces	69	32	CHAR	As provided by the ACO-OS

Table 77: DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is trailer information for the DME PCF Provider file	1	7	CHAR	TRL_PRV
File Creation Date	Date when the file was created	8	8	CHAR	CCYYMMDD
Detail Record Count	Number of detail rows or records sent by ACO-OS	16	10	NUM	Numbers
Filler	Unused area filled with spaces	26	75	CHAR	Blanks

Table 78: DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider Response File Trailer

Data Field	Description	Start Position	Length	Format	Valid Values
Record Identifier	Record indicator which identifies the line entry is header information for the DME PCF Provider file	1	7	CHAR	As provided by the ACO-OS
Response Code	Response code indicating if the record was processing successfully or not	8	2	NUM	Valid values are documented and explained in Appendix A: Response Codes and Explanations
File Creation Date	Date the file is created	10	8	CHAR	As provided by the ACO-OS
Detail Record Count	Number of detail rows or records sent by ACO-OS	18	10	NUM	As provided by the ACO-OS
Filler	Unused area filled with spaces	28	73	CHAR	As provided by the ACO-OS

5.13.4.3 Filenames

The file naming convention for the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider file sent by the ACO-OS to the VMS at the HP VDC will be **P#EFT.ON.########.PCFPRD.Dyymmdd.Thhmmsst**. For example, an outbound file for January 4, 2021, at 10:00 AM to the VMS would be:

P#EFT.ON.########.PCFPRV.D210104.T1000000.

The file naming convention for the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider Response file sent by the MCS to the ACO-OS will be **P#EFT.ON.ACOT.#######.PCPR.Dyymmdd.Thhmmsst**. For example, an inbound file from the VMS corresponding to the above file sent from the ACO-OS would be:

P#EFT.ON.ACOT.#######.PCPR.D210104.T1000000.

5.13.5 Communication Methods

This section describes communication methods that the interface uses, as well as error recovery.

5.13.5.1 Interface Initiation

The ACO-OS sends the DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider file to the VMS.

5.13.5.2 Flow Control

The ACO-OS DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider files are transferred to the VMS using EFT. If there are any problems transferring data from the ACO-OS, the EFT error handling mechanism provides notice with details to whichever side, sending or receiving, is impacted and logs the errors for follow up investigations, if needed.

5.13.6 Security Requirements

For information on security requirements, see Section 4.5, Security and Integrity.

6 Qualification Methods

Developers perform initial data processing, cross-check testing, and system integration testing.

Appendix A: Response Codes and Explanations

The following table lists the Response/Error codes to be provided by the FFS SSMs when an error is encountered upon validation of files sent from the ACO-OS.

Table 79: Response Codes and Explanations

Code	Description	Explanation	Applies to Provider or Beneficiary or both
00	Success	The record was processed successfully.	Beneficiary or Provider
10	Header Record ID Error	The Header contains a Record ID but the last three characters are not PRV or BEN.	Beneficiary or Provider
11	Header Record Date Error	The Header Record date is missing or invalid.	Beneficiary or Provider
20	Detail Record ID Error	The data in the file does not conform to the file layout specified for the file transfer. The data format of the field or the data in the field does not conform to the list of valid values specified.	Beneficiary or Provider
21	Missing ACO Identifier applies to all ACO Program/models as follows: NGACO/VT APM/CEC/DC/KCC/KCF/PCF ACO/ESCO/Entity ID Error	The NGACO/VT APM/CEC/DC/KCC/KCF/PCF ID is missing or invalid.	Beneficiary or Provider
22	TIN Error	The Provider Taxpayer Identification Number (TIN) is missing or invalid.	Provider
24	CCN Error	The Provider CCN is missing or invalid on the Part A file.	Provider
25	Effective Start Date Error	The Effective Start Date is missing or invalid.	Beneficiary or Provider
26	Effective End Date Error	The Effective End Date is missing or invalid.	Beneficiary or Provider
29	Beneficiary HICN Error	The Beneficiary HICN is missing or invalid.	Beneficiary

Code	Description	Explanation	Applies to Provider or Beneficiary or both
30	Trailer Record ID Error	The Trailer contains a Record ID but the last three characters are not PRV or BEN.	Beneficiary or Provider
31	Trailer Record Date Error	The Trailer Record Date is missing or invalid.	Beneficiary or Provider
32	Trailer Record Count Error	The error occurs when the record count does not equal the number of data records. (or) The trailer record is located before the end of the file. (or) There is a header and trailer, but no detail records.	Beneficiary or Provider
98	Header Record Missing	The Header record is missing or does not begin with HDR_.	Beneficiary or Provider
99	Trailer Record Missing	The Trailer record is missing or does not begin with TRL_.	Beneficiary or Provider

Appendix B: NGACO and VT APM Pass-Through File

NGACO Weekly AIPBP Reduction File:
The following file is prepared by CWF and provided to RACS utilizing EFT; this file is then moved from RACS via EFT to the Entities.

Table 80: NGACO Pass-Through Files

Description	Frequency	Filename	File Format	Logical Record Length	Size Estimate	Scheduled Date
Weekly AIPBP Reduction File	Weekly	P#EFT.ON.ACOT.V***.AIPBPRD.Dyymmdd.Thhmmsst	Text	800 Bytes	TBD	TBD

The file naming convention for the Weekly AIPBP Reduction File, sent by the CWF to Entities, will be P#EFT.ON.ACOT.V***.AIPBPRD.Dyymmdd.Thhmmsst for the NGACO Entities

The Weekly AIPBP Reduction filename in the ACO's mailbox will be P.V***.AIPBPRD.RP.Dyymmdd.Thhmmsst

Note: CWF will send both "CLMH-MBI" and "CLMH-HIC-NUM" as the beneficiary identifiers in the NGACO Weekly AIPBP Reduction file during the New Medicare Card Project transition period. After the end of the transition period (December 2019), only "CLMH-MBI" will be populated and "CLMH-HIC-NUM" will be populated as blanks.

VT APM Weekly AIPBP Reduction File:

The following file is prepared by CWF and provided to RACS utilizing EFT; this file is then moved from RACS via EFT to the Entities.

Table 81: VT APM Pass-Through Files

Description	Frequency	Filename	File Format	Logical Record Length	Size Estimate	Scheduled Date
Weekly AIPBP Reduction File	Weekly	P#EFT.ON.ACOT.F***.AIPBPRD.Dyymmdd.Thhmmsst	Text	800 Bytes	TBD	TBD

The file naming convention for the Weekly AIPBP Reduction File, sent by the CWF to Entities, will be P#EFT.ON.ACOT.F***.AIPBPRD.Dyymmdd.Thhmmsst for the VT APM Entities.

The Weekly AIPBP Reduction filename in the ACO's mailbox will be P.F***.AIPBPRD.RP.Dyymmdd.Thhmmsst.

Note: CWF will send both "CLMH-MBI" and "CLMH-HIC-NUM" as the beneficiary identifiers in the VTAPM Weekly AIPBP Reduction file during the New Medicare Card Project transition period. After the end of the transition period (December 2019), only "CLMH-MBI" will be populated and "CLMH-HIC-NUM" will be populated as blanks.

NGACO/VT APM Weekly AIPBP Reduction File Layout:

Table 82: NGACO/VT APM Weekly AIPBP Reduction File Header

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CLMH-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"
2	CLMH-CNTRCTR-NUM	Contractor Number	5	9	5	X(05)	Identification number of contractor submitting claim.
3	CLMH-ACO-ID	ACO ID	10	19	10	X(10)	ACO identification number.
4	CLMH-HIC-NUM	Beneficiary's Health Insurance Claim Number	20	31	12	X(12)	Blanks
5	CLMH-MBI	Medicare Beneficiary Identifier	32	42	11	X(11)	MBI is a beneficiary identifier.
6	CLMH-DCN	DCN	43	65	23	X(23)	Carrier assigned Document Control Number for claim.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	CLMH-XREF-DCN	XREF DCN	66	88	23	X(23)	Cross-reference Document Control Number assigned to claim. Note: This field only applies to Part A.
8	CLMH-FROM-DT	From Date	89	96	8	YYYY MMDD	This date is the first day on the billing statement that covers services rendered to the beneficiary. This date is also known as “Statement Covers From Date”. Note: This applies only to Part A.
9	CLMH-THRU-DT	Thru Date	97	104	8	YYYY MMDD	This date is the last day on the billing statement that covers services rendered to the beneficiary. This date is also known as the “Statement Covers Through Date”. Note: This applies to only Part A.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
10	CLMH-PVDR-CCN	Provider CCN	105	110	6	X(06)	The CCN for the ACO Provider. This number verifies that a provider has been Medicare-certified for a particular type of services.
11	CLMH-PVDR-NPI	Provider NPI	111	120	10	X(10)	NPI Number is a unique identification number for covered health care providers. Covered health care providers must use the NPIs in administrative and financial transactions.
12	CLMH-TYPE-OF-BILL	Type of Bill	121	123	3	X(03)	A code that indicates the specific type of claim (Inpatient, Outpatient, adjustments, voids, etc.).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
13	CLMH-BILL-FACILITY	Bill Facility	121	121	1	X(01)	This code is the first digit of the type of bill (TOB1), and is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are: 1= Hospital 2= SNF 3= Home Health Agency (HHA) 4= Religious non-medical (hospital) 5= Religious non-medical (extended care) 6= Intermediate care 7= Clinic or hospital-based renal dialysis facility 8= Specialty facility or Ambulatory Surgical Center (ASC) surgery 9= Reserved

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
14	CLMH-BILL-CATEGORY	Bill Category	122	122	1	X(01)	This code is the second digit of the type of bill (TOB2), and it is used to indicate with greater specificity where the service was provided (e.g. a department within a hospital) Claim Service Classification Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Service-classification-Type-Code).
15	CLMH-BILL-FREQUENCY	Bill Frequency	123	123	1	X(01)	This is the third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided). Claim Frequency Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Frequency-Code).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
16	CLMH-ADJSMT-TYPE-CD	Adjustment Type Code	124	124	1	X(01)	This code indicates whether the claim is an original, cancellation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Credit 2=Debit
17	CLMH-PAYMENT-AMT	Claim Payment Amount	125	134	10	S9(08) V99	The amount that Medicare paid on the claim.
18	CLMH-AIPBP-RED-AMT	All Inclusive Population Based Payments Reduction Amount	135	144	10	S9(08) V99	Total payment amount with AIPBP reduction percent applied. Note: This will be the amount in Value Code 'Q1' for Part A.
19	CLMH-DRG-CODE	Diagnosis Related Group Code	145	147	3	9(03)	This code indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
20	CLMH-DGNS-ADMITTING	Admitting Diagnosis Code	148	154	7	X(07)	The ICD-9/10 diagnosis code identifying the illness or disability for which the beneficiary was admitted.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
21	CLMH-DGNS-EXTERNAL	DGNS External	155	161	7	X(07)	The ICD-9/ICD-10 diagnosis code which describes the external cause of the injury. Note: CWF is using external cause of injury first diagnosis code.
22	CLMH-PAT-VISIT-REAS1	Patient Visit Reason 1	162	168	7	X(07)	Diagnosis code for patient's first visit.
23	CLMH-PAT-VISIT-REAS2	Patient Visit Reason 2	169	175	7	X(07)	Diagnosis code for patient's second visit.
24	CLMH-PAT-VISIT-REAS3	Patient Visit Reason 3	176	182	7	X(07)	Diagnosis code for patient's third visit.
25	CLMH-PRCDR-DATA		183	557	375		
26	CLMH-PRCDR-ENTRY	Procedure Entry					Procedure Codes and Dates Occurs 25 times.
27	CLMH-PRCDR-CD	Procedure Code	183	189	7	X(07)	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim.
28	CLMH-PRCDR-DT	Procedure Date	190	197	8	YYYY MMDD	The date the indicated procedure was performed.
29	CLMH-DIAG-DATA		558	757	200		

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
30	CLMH-DIAG-ENTRY	Diagnosis Entry					Diagnosis Codes and POA indicators. Occurs 25 times.
31	CLMH-DIAG-CODE	Diagnosis Code	558	564	7	X(07)	The patient's ICD-9/ICD-10 diagnosis code.
32	CLMH-DIAG-POA-IND	Diagnosis Code Present On Admission Indicator	565	565	1	X(01)	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility.
33	CLMH-DETAIL-LINES	Detail Lines	758	760	3	S9(03)	Number of line items on claim.
34	CLMH-PATIENT-NUM	Patient Control Number	761	780	20	X(20)	Patient Control Number
35	FILLER1	Filler	781	800	20	X(20)	Filler

Table 83: NGACO/VT APM Weekly AIPBP Reduction File Detail

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CLML-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: “CLMH” “CLML”
2	CLML-LINE-NUMBER	Claim Line Number	5	7	3	S9(03)	This number is a sequential number that identifies a specific claim line.
3	CLML-REV-CD	Revenue Code	8	11	4	9(04)	Claim Revenue center code identifies a specific accommodation, ancillary service, or billing calculation. Note: Include REV Code 0001.
4	CLML-RNDRG-PRVDR-TAX-NUM	Rendering Provider Tax Number	12	21	10	X(10)	The rendering provider’s Internal Revenue Employer Identification number or Social Security number. Note: Billing TIN is always the same as Rendering TIN for Part B.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
5	CLML-RNDRG-PRVDR-NPI-NUM	Rendering Provider National Provider Identifier Number	22	31	10	X(10)	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI. Note: This will only apply to Part B.
6	CLML-DGNS-CD-1	Claim Line Diagnosis First Code	32	38	7	X(07)	The first of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	CLML-DGNS-CD-2	Claim Line Diagnosis Second Code	39	45	7	X(07)	The second of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
8	CLML-DGNS-CD-3	Claim Line Diagnosis Third Code	46	52	7	X(07)	The third of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
9	CLML-DGNS-CD-4	Claim Line Diagnosis Fourth Code	53	59	7	X(07)	The fourth of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
10	CLML-FROM-DATE	Claim Line From Date	60	67	8	YYYY MMDD	This is the date the service associated with the line item began. *UPDATE: CWF will carry the detail line item date for Part A in both the From and Thru Date.*
11	CLML-THRU-DATE	Claim Line Thru Date	68	75	8	YYYY MMDD	This is the date the service associated with the line item ended.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
12	CLML-SRVC-UNIT-QTY	Claim Line Service Unit Quantity	76	82	7	S9(07)	Total units associated with services needing unit reporting such as number of covered days in a particular accommodation, miles, Anesthesia times the units and number of oxygen or blood units.
13	CLML-TOT-CHRG-AMT	Claim Line Total Charge Amount	83	92	10	S9(08) V99	Total submitted charge for line item. Note: CWF will also be providing charges for non-covered and denied services.
14	CLML-ALOWD-CHRG-AMT	Claim Line Allowed Charge Amount	93	99	7	S9(05) V99	The amount Medicare approved for payment to the provider. Note: Part B only
15	CLML-CVRD-PD-AMT	Claim Line Covered Paid Amount	100	106	7	S9(05) V99	This is the amount Medicare reimbursed the provider for covered services associated with the claim-line and is based on the Total Charge minus the Non-Covered Charge.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
16	CLML-AIPBP-RED-AMT	All Inclusive Population Based Payments Reduction Amount	107	113	7	S9(05) V99	Total payment amount with AIPBP reduction percent applied. Note: This will be the Other Amount carried for 'L' for Part B. CWF will use Other Amount Indicator 'L' to calculate the AIPBP-reduced amount.
17	CLML-HCPC-CD	Healthcare Common Procedure Coding System (HCPCS) Code	114	118	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
18	CLML-HCPC-MODIFIER1	HCPCS First Modifier Code	119	120	2	X(02)	This is the first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
19	CLML-HCPC-MODIFIER2	HCPCS Second Modifier Code	121	122	2	X(02)	This is the second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
20	CLML-HCPC-MODIFIER3	HCPCS Third Modifier Code	123	124	2	X(02)	This is the third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
21	CLML-HCPC-MODIFIER4	HCPCS Fourth Modifier Code	125	126	2	X(02)	This is the fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
22	CLML-HCPC-MODIFIER5	HCPCS Fifth Modifier Code	127	128	2	X(02)	This is the fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. Note: This applies only to Part A.
23	FILLER	Filler	129	136	8	X(08)	

Appendix C: Direct Contracting Pass-Through File

Direct Contracting (Direct Contracting) Weekly APO/PCC/TCC Reduction File:
The following file is prepared by CWF from 01/01/2021 and provided to RACS utilizing EFT; this file is then moved from RACS via EFT to the Entities.

Table 84: Direct Contracting Pass-Through Files

Description	Frequency	Filename	File Format	Logical Record Length	Size Estimate	Scheduled Date
Weekly APO/PCC/TCC Reduction File	Weekly	P#EFT.ON.ACOT.D***.TCPCAPRC.Dyymmdd.Thhmmsst	Text	800 Bytes	TBD	TBD

The file naming convention for the Weekly APO/PCC/TCC Reduction File, sent by the CWF to Entities, will be **P#EFT.ON.ACOT.D***.TCPCAPRC.Dyymmdd.Thhmmsst** for the Direct Contracting Entities

The Weekly APO/PCC/TCC Reduction filename in the ACO's mailbox will be **P.D***.TCPCAPRC.RP.Dyymmdd.Thhmmsst**.

Note: CWF will send both "CLMH-MBI" and "CLMH-HIC-NUM" as the beneficiary identifiers in the Direct Contracting Weekly APO/PCC/TCC Reduction file during the New Medicare Card Project transition period. The field "CLMH-MBI" will be populated and "CLMH-HIC-NUM" will be populated as blanks.

Direct Contracting Weekly APO/PCC/TCC Reduction File Layout:

Table 85: Direct Contracting Weekly APO/PCC/TCC Reduction File Header

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
36	CLMH-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"
37	FILLER	Delimiter	5	5	1	X(01)	; (Semi colon)
38	CLMH-CNTRCTR-NUM	Contractor Number	6	10	5	X(05)	Identification number of contractor submitting claim.
39	FILLER	Delimiter	11	11	1	X(01)	; (Semi colon)
40	CLMH-ACO-IDENTIFIER		12	22	10	X(11)	ACO identification number.
41	CLMH-QUAL-ID	ACO ID	12	12	1	X(01)	
42	FILLER	Delimiter	13	13	1	X(01)	; (Semi colon)
43	CLMH-ACO-ID-NUMBER	ACO NUMBER	14	22	9	X(09)	
44	FILLER	Delimiter	23	23	1	X(01)	; (Semi colon)
45	CLMH-MEDICARE-PART	Claim Type	24	27	4	X(04)	FISS or MCS
46	FILLER	Delimiter	28	28	1	X(01)	; (Semi colon)
47	CLMH-MBI	Medicare Beneficiary Identifier	29	39	11	X(11)	MBI is a beneficiary identifier.
48	FILLER	Delimiter	40	40	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
49	CLMH-DCN	DCN	41	63	23	X(23)	Carrier assigned Document Control Number for claim.
50	FILLER	Delimiter	64	64	1	X(01)	; (Semi colon)
51	CLMH-XREF-DCN	XREF DCN	65	87	23	X(23)	Cross-reference Document Control Number assigned to claim. Note: This field only applies to Part A. This field will contain the same value as in DCN for part B claims.
52	FILLER	Delimiter	88	88	1	X(01)	; (Semi colon)
53	CLMH-FROM-DT	From Date	89	96	8	YYYY MMDD	This date is the first day on the billing statement that covers services rendered to the beneficiary. This date is also known as “Statement Covers From Date”. Note: This applies only to Part A.
54	FILLER	Delimiter	97	97	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
55	CLMH-THRU-DT	Thru Date	98	105	8	YYYY MMDD	This date is the last day on the billing statement that covers services rendered to the beneficiary. This date is also known as the “Statement Covers Through Date”. Note: This applies to only Part A.
56	FILLER	Delimiter	106	106	1	X(01)	; (Semi colon)
57	CLMH-PVDR-CCN	Provider CCN	107	112	6	X(06)	The CCN for the ACO Provider. This number verifies that a provider has been Medicare-certified for a particular type of services.
58	FILLER	Delimiter	113	113	1	X(01)	; (Semi colon)
59	CLMH-PVDR-NPI	Provider NPI	114	123	10	X(10)	NPI Number is a unique identification number for covered health care providers. Covered health care providers must use the NPIs in administrative and financial transactions.
60	FILLER	Delimiter	124	124	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
61	CLMH-TYPE-OF-BILL	Type of Bill	125	130	6	X(06)	A code that indicates the specific type of claim (Inpatient, Outpatient, adjustments, voids, etc.).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
62	CLMH-BILL-FACILITY	Bill Facility	125	125	1	X(01)	This code is the first digit of the type of bill (TOB1), and is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are: 1= Hospital 2= SNF 3= Home Health Agency (HHA) 4= Religious non-medical (hospital) 5= Religious non-medical (extended care) 6= Intermediate care 7= Clinic or hospital-based renal dialysis facility 8= Specialty facility or Ambulatory Surgical Center (ASC) surgery 9= Reserved
63	FILLER	Delimiter	126	126	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
64	CLMH-BILL-CATEGORY	Bill Category	127	127	1	X(01)	This code is the second digit of the type of bill (TOB2), and it is used to indicate with greater specificity where the service was provided (e.g. a department within a hospital) Claim Service Classification Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Service-classification-Type-Code).
65	FILLER	Delimiter	128	128	1	X(01)	; (Semi colon)
66	CLMH-BILL-FREQUENCY	Bill Frequency	129	129	1	X(01)	This is the third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided). Claim Frequency Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Frequency-Code).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
67	FILLER	Delimiter	130	130	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
68	CLMH-ADJSMT-TYPE-CD	Adjustment Type Code	131	131	1	X(01)	This code indicates whether the claim is an original, cancellation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Credit 2=Debit
69	FILLER	Delimiter	132	132	1	X(01)	; (Semi colon)
70	CLMH-ADJUST-REASON-CODE	Adjustment Reason Code	133	135	1	X(03)	Reason code for claim adjustment, for example: - Beneficiary Alignment Change (Value 'B') - Provider Alignment Change (Value 'P') - Other (Value 'O')

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
71	FILLER	Delimiter	136	136	1	X(01)	; (Semi colon)
72	CLMH-REIMB-AMT	Claim Payment Amount	137	147	11	X(11)	The amount that Medicare paid on the claim. $$$$$$$$:99
73	FILLER	Delimiter	148	148	1	X(01)	; (Semi colon)
74	CLMH-BENE-PMT-COINSRNC-AMT	Claim Beneficiary Payment Coinsurance Amount	149	159	11	X(11)	An amount identifying the portion of cost that is the responsibility of a beneficiary for payment. $$$$$$$$:99 Only for FISS (Part A) Value-code – 'A2'
75	FILLER	Delimiter	160	160	1	X(01)	; (Semi colon)
76	CLMH-RCPNT-PMT-DDCTBL-PD-AMT	Claim Recipient Payment Deductible Paid Amount	161	168	8	X(08)	The amount of money the beneficiary paid towards an annual deductible. $$$$$:99 Only for FISS (Part A) Value-code – 'A1'

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
77	FILLER	Delimiter	169	169	1	X(01)	; (Semi colon)
78	CLMH-APO-RED-AMT	Advanced Payment Option Reduction Amount	170	177	8	X(08)	Total payment amount with PBP reduction percent applied. (For DC/KCC, Benefit Enhancement “1”). $$$$$:99 Only for FISS (Part A) Value-code – ‘Q1’
79	FILLER	Delimiter	178	178	1	X(01)	; (Semi colon)
80	CLMH-TCC-RED-AMT	Total Care Capitation Payment Reduction Amount	179	186	8	X(08)	(For DC/KCC, Benefit Enhancement “5”). $$$$$:99 Only for FISS (Part A) Value-code – ‘Q1’
81	FILLER	Delimiter	187	187	1	X(01)	; (Semi colon)
82	CLMH-PCC-RED-AMT	Primary Care Capitation Payment Reduction Amount	188	195	8	X(08)	(For DC/KCC, Benefit Enhancement “8”). $$$$$:99 Only for FISS (Part A) Value-code – ‘Q1’
83	FILLER	Delimiter	196	196	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
84	CLMH-DRG-CODE	Diagnosis Related Group Code	197	199	3	9(03)	This code indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
85	FILLER	Delimiter	200	200	1	X(01)	; (Semi colon)
86	CLMH-DGNS-ADMITTING	Admitting Diagnosis Code	201	207	7	X(07)	The ICD-9/10 diagnosis code identifying the illness or disability for which the beneficiary was admitted.
87	FILLER	Delimiter	208	208	1	X(01)	; (Semi colon)
88	CLMH-DGNS-EXTERNAL	DGNS External	209	215	7	X(07)	The ICD-9/ICD-10 diagnosis code which describes the external cause of the injury. Note: CWF is using external cause of injury first diagnosis code.
89	FILLER	Delimiter	216	216	1	X(01)	; (Semi colon)
90	CLMH-PAT-VISIT-REAS1	Patient Visit Reason 1	217	223	7	X(07)	Diagnosis code for patient's first visit.
91	FILLER	Delimiter	224	224	1	X(01)	; (Semi colon)
92	CLMH-PAT-VISIT-REAS2	Patient Visit Reason 2	225	231	7	X(07)	Diagnosis code for patient's second visit.
93	FILLER	Delimiter	232	232	1	X(01)	; (Semi colon)
94	CLMH-PAT-VISIT-REAS3	Patient Visit Reason 3	233	239	7	X(07)	Diagnosis code for patient's third visit.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
95	FILLER	Delimiter	240	240	1	X(01)	; (Semi colon)
96	CLMH-PRCDR-DATA		241	665	425		
97	CLMH-PRCDR-ENTRY	Procedure Entry	241	257	17		Procedure Codes and Dates Occurs 25 times.
98	CLMH-PRCDR-CD	Procedure Code	241	247	7	X(07)	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim.
99	FILLER	Delimiter	248	248	1	X(01)	; (Semi colon)
100	CLMH-PRCDR-DT	Procedure Date	249	256	8	YYYY MMDD	The date the indicated procedure was performed.
101	FILLER	Delimiter	257	257	1	X(01)	; (Semi colon)
102	CLMH-DIAG-DATA		666	915	250		
103	CLMH-DIAG-ENTRY	Diagnosis Entry	666	675	10		Diagnosis Codes and POA indicators. Occurs 25 times.
104	CLMH-DIAG-CODE	Diagnosis Code	666	672	7	X(07)	The patient's ICD-9/ICD-10 diagnosis code.
105	FILLER	Delimiter	673	673	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
106	CLMH-DIAG-POA-IND	Diagnosis Code Present On Admission Indicator	674	674	1	X(01)	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility.
107	FILLER	Delimiter	675	675	1	X(01)	; (Semi colon)
108	CLMH-DETAIL-LINES	Detail Lines	916	918	3	9(03)	Number of line items on claim.
109	FILLER	Delimiter	919	919	1	X(01)	; (Semi colon)
110	CLMH-PATIENT-NUM	Patient Control Number	920	939	20	X(20)	Patient Control Number
111	FILLER	Delimiter	940	940	1	X(01)	; (Semi colon)
112	FILLER1	Filler	941	985	45	X(45)	Filler

Table 86: Direct Contracting Weekly APO/PCC/TCC Reduction File Detail

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CLML-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"
2	FILLER	Delimiter	5	5	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
3	CLML-LINE-NUMBER	Claim Line Number	6	8	3	9(03)	This number is a sequential number that identifies a specific claim line.
4	FILLER	Delimiter	9	9	1	X(01)	; (Semi colon)
5	CLML-REV-CD	Revenue Code	10	13	4	9(04)	Claim Revenue center code identifies a specific accommodation, ancillary service, or billing calculation. Note: Include REV Code 0001.
6	FILLER	Delimiter	14	14	1	X(01)	; (Semi colon)

Table 35 Cont'd

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	CLML-RNDRG-PRVDR-TAX-NUM	Rendering Provider Tax Number	15	24	10	X(10)	The rendering provider's Internal Revenue Employer Identification number or Social Security number. Note: Billing TIN is always the same as Rendering TIN for Part B.
8	FILLER	Delimiter	25	25	1	X(01)	; (Semi colon)
9	CLML-RNDRG-PRVDR-NPI-NUM	Rendering Provider National Provider Identifier Number	26	35	10	X(10)	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI. Note: This will only apply to Part B.
10	FILLER	Delimiter	36	36	1	X(01)	; (Semi colon)

Table 35 Cont'd

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
11	CLML-DGNS-CD-1	Claim Line Diagnosis First Code	37	43	7	X(07)	The first of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.
12	FILLER	Delimiter	44	44	1	X(01)	; (Semi colon)

Table 35 Cont'd

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
13	CLML-DGNS-CD-2	Claim Line Diagnosis Second Code	45	51	7	X(07)	The second of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.
14	FILLER	Delimiter	52	52	1	X(01)	; (Semi colon)

Table 35 Cont'd

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
15	CLML-DGNS-CD-3	Claim Line Diagnosis Third Code	53	59	7	X(07)	The third of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.
16	FILLER	Delimiter	60	60	1	X(01)	; (Semi colon)

Table 35 Cont'd

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
17	CLML-DGNS-CD-4	Claim Line Diagnosis Fourth Code	61	67	7	X(07)	The fourth of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.
18	FILLER	Delimiter	68	68	1	X(01)	; (Semi colon)
19	CLML-FROM-DATE	Claim Line From Date	69	76	8	YYYY MMDD	This is the date the service associated with the line item began. UPDATE: CWF will carry the detail line item date for Part A in both the From and Thru Date.
20	FILLER	Delimiter	77	77	1	X(01)	; (Semi colon)

Table 35 Cont'd

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
21	CLML-THRU-DATE	Claim Line Thru Date	78	85	8	YYYY MMDD	This is the date the service associated with the line item ended.
22	FILLER	Delimiter	86	86	1	X(01)	; (Semi colon)
23	CLML-SRVC-UNIT-QTY	Claim Line Service Unit Quantity	87	93	7	9(07)	Total units associated with services needing unit reporting such as number of covered days in a particular accommodation, miles, Anesthesia times the units and number of oxygen or blood units.
24	FILLER	Delimiter	94	94	1	X(01)	; (Semi colon)
25	CLML-TOT-CHRG-AMT	Claim Line Total Charge Amount	95	105	11	X(11)	Total submitted charge for line item. $$$$$$$$:99 Note: CWF will also be providing charges for non-covered and denied services.
26	FILLER	Delimiter	106	106	1	X(01)	; (Semi colon)
27	CLML-ALOWD-CHRG-AMT	Claim Line Allowed Charge Amount	107	114	8	X(08)	The amount Medicare approved for payment to the provider. $$$$$:99 Note: Part B only

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
28	FILLER	Delimiter	115	115	1	X(01)	; (Semi colon)

Table 35 Cont'd

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
29	CLML-CVRD-PD-AMT	Claim Line Covered Paid Amount	116	126	11	X(11)	This is the amount Medicare reimbursed the provider for covered services associated with the claim-line and is based on the Total Charge minus the Non-Covered Charge. $$$$$$$:99
30	FILLER	Delimiter	127	127	1	X(01)	; (Semi colon)
31	CLML-BENE-PMT-COINSRNC-AMT	Claim Beneficiary Payment Coinsurance Amount	128	136	9	X(09)	An amount identifying the portion of cost that is the responsibility of a beneficiary for payment. $$$$$:99 (MCS Part B only)
32	FILLER	Delimiter	137	137	1	X(01)	; (Semi colon)
33	CLML-RCPNT-PMT-DDCTBL-PD-AMT	Claim Recipient Payment Deductible Paid Amount	138	145	8	X(08)	The amount of money the beneficiary paid towards an annual deductible. $$$$:99 (MCS Part B only)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
34	FILLER	Delimiter	146	146	1	X(01)	; (Semi colon)
35	CLML-APO-RED-AMT	Advanced Payment Option Reduction Amount	147	154	8	X(08)	(For DC/KCC, Benefit Enhancement “1”). (MCS Part B only) $$$$$:99 Other-amts-ind - ‘L’
36	FILLER	Delimiter	155	155	1	X(01)	; (Semi colon)
37	CLML-TCC-RED-AMT	Total Care Capitation Reduced Amount	156	163	8	X(08)	(For DC/KCC, Benefit Enhancement “5”). (MCS Part B only) $$$$$:99 Other-amts-ind - ‘L’
38	FILLER	Delimiter	164	164	1	X(01)	; (Semi colon)
39	CLML-PCC-RED-AMT	Primary Care Capitation Payment Reduction Amount	165	172	8	X(08)	Total payment amount with PCC reduction percent applied. (For DC/KCC, Benefit Enhancement “8”). (MCS Part B only) $$$$$:99 Other-amts-ind - ‘L’
40	FILLER	Delimiter	173	173	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
41	CLML-HCPC-CD	Healthcare Common Procedure Coding System (HCPCS) Code	174	178	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
42	FILLER	Delimiter	179	179	1	X(01)	; (Semi colon)

Table 35 Cont'd

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
43	CLML-HCPC-MODIFIER1	HCPCS First Modifier Code	180	181	2	X(02)	This is the first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
44	FILLER	Delimiter	182	182	1	X(01)	; (Semi colon)
45	CLML-HCPC-MODIFIER2	HCPCS Second Modifier Code	183	184	2	X(02)	This is the second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
46	FILLER	Delimiter	185	185	1	X(01)	; (Semi colon)
47	CLML-HCPC-MODIFIER3	HCPCS Third Modifier Code	186	187	2	X(02)	This is the third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
48	FILLER	Delimiter	188	188	1	X(01)	; (Semi colon)
49	CLML-HCPC-MODIFIER4	HCPCS Fourth Modifier Code	189	190	2	X(02)	This is the fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
50	FILLER	Delimiter	191	191	1	X(01)	; (Semi colon)
51	CLML-HCPC-MODIFIER5	HCPCS Fifth Modifier Code	192	193	2	X(02)	This is the fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. Note: This applies only to Part A.
52	FILLER	Delimiter	194	194	1	X(01)	; (Semi colon)
53	FILLER	Filler	195	225	31	X(31)	N/A

Appendix D: CKCC Pass-Through File

CKCC Weekly Capitated (TCC/QCP) Reduction File:

The following file is prepared by CWF from 01/01/2021 and provided to RACS utilizing EFT; this file is then moved from RACS via EFT to the Entities.

Table 87: CKCC Choices Pass-Through Files

Description	Frequency	Filename	File Format	Logical Record Length	Size Estimate	Scheduled Date
Weekly TCC/QCP Reduction File	Weekly	P#EFT.ON.ACOT.C***.TCCQCPRC.Dyymmdd.Thhmmsst	Text	800 Bytes	TBD	TBD

The file naming convention for the Weekly TCC/QCP Reduction File, sent by the CWF to Entities, will be P#EFT.ON.ACOT.C****.TCCQCPRC.Dyymmdd.Thhmmsst for the CKCC Entities

The Weekly TCC/QCP Reduction filename in the ACO's mailbox will be P.C****.TCCQCPC.RP.Dyymmdd.Thhmmsst.

Note: CWF will send both "CLMH-MBI" and "CLMH-HIC-NUM" as the beneficiary identifiers in the CKCC *Weekly TCC/QCP Reduction file during the New Medicare Card Project transition period. After the end of the transition period (December 2019), only "CLMH-MBI" will be populated and "CLMH-HIC-NUM" will be populated as blanks.*

Table 88: CKCC Entities Weekly TCC/QCP Reduction File Layout

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CLMH-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"
2	FILLER	Delimiter	5	5	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
3	CLMH-CNTRCTR-NUM	Contractor Number	6	10	5	X(05)	Identification number of contractor submitting claim.
4	FILLER	Delimiter	11	11	1	X(01)	; (Semi colon)
5	CLMH-ACO-IDENTIFIER		12	22	10	X(11)	ACO identification number.
6	CLMH-QUAL-ID	ACO ID	12	12	1	X(01)	
7	FILLER	Delimiter	13	13	1	X(01)	; (Semi colon)
8	CLMH-ACO-ID-NUMBER	ACO NUMBER	14	22	9	X(09)	
9	FILLER	Delimiter	23	23	1	X(01)	; (Semi colon)
10	CLMH-MEDICARE-PART	Claim Type	24	28	5	X(05)	Part A or Part B paid for the claim.
11	FILLER	Delimiter	29	29	1	X(01)	; (Semi colon)
12	CLMH-MBI	Medicare Beneficiary Identifier	30	40	11	X(11)	MBI is a beneficiary identifier.
13	FILLER	Delimiter	41	41	1	X(01)	; (Semi colon)
14	CLMH-DCN	DCN	42	64	23	X(23)	Carrier assigned Document Control Number for claim.
15	FILLER	Delimiter	65	65	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
16	CLMH-XREF-DCN	XREF DCN	66	88	23	X(23)	Cross-reference Document Control Number assigned to claim. *Note: This field only applies to Part A.*
17	FILLER	Delimiter	89	89	1	X(01)	; (Semi colon)
18	CLMH-FROM-DT	From Date	90	97	8	YYYY MMDD	This date is the first day on the billing statement that covers services rendered to the beneficiary. This date is also known as “Statement Covers From Date”. *Note: This applies only to Part A.*
19	FILLER	Delimiter	98	98	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
20	CLMH-THRU-DT	Thru Date	99	106	8	YYYY MMDD	This date is the last day on the billing statement that covers services rendered to the beneficiary. This date is also known as the "Statement Covers Through Date". *Note: This applies to only Part A.*
21	FILLER	Delimiter	107	107	1	X(01)	; (Semi colon)
22	CLMH-PVDR-CCN	Provider CCN	108	113	6	X(06)	The CCN for the ACO Provider. This number verifies that a provider has been Medicare-certified for a particular type of services.
23	FILLER	Delimiter	114	114	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
24	CLMH-PVDR-NPI	Provider NPI	115	124	10	X(10)	NPI Number is a unique identification number for covered health care providers. Covered health care providers must use the NPIs in administrative and financial transactions.
25	FILLER	Delimiter	125	125	1	X(01)	; (Semi colon)
26	CLMH-TYPE-OF-BILL	Type of Bill	126	131	6	X(06)	A code that indicates the specific type of claim (Inpatient, Outpatient, adjustments, voids, etc.).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
27	CLMH-BILL-FACILITY	Bill Facility	126	126	1	X(01)	This code is the first digit of the type of bill (TOB1), and is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are: 1 = Hospital 2 = SNF 3 = Home Health Agency (HHA) 4 = Religious non-medical (hospital) 5 = Religious non-medical (extended care) 6 = Intermediate care 7 = Clinic or hospital-based renal dialysis facility 8 = Specialty facility or Ambulatory Surgical Center (ASC) surgery 9 = Reserved

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
28	FILLER	Delimiter	127	127	1	X(01)	; (Semi colon)
29	CLMH-BILL-CATEGORY	Bill Category	128	128	1	X(01)	This code is the second digit of the type of bill (TOB2), and it is used to indicate with greater specificity where the service was provided (e.g. a department within a hospital) Claim Service Classification Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Service-classification-Type-Code).
30	FILLER	Delimiter	129	129	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
31	CLMH-BILL-FREQUENCY	Bill Frequency	130	130	1	X(01)	This is the third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided). Claim Frequency Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Frequency-Code).
32	FILLER	Delimiter	131	131	1	X(01)	; (Semi colon)
33	CLMH-ADJSMT-TYPE-CD	Adjustment Type Code	132	132	1	X(01)	This code indicates whether the claim is an original, cancellation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Credit 2=Debit
34	FILLER	Delimiter	133	133	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
35	CLMH-ADJUST-REASON-CODE	Adjustment Reason Code	134	136	1	X(03)	Reason code for claim adjustment, for example: • IUR • Beneficiary Alignment Change • Provider Alignment Change • Other
36	FILLER	Delimiter	137	137	1	X(01)	; (Semi colon)
37	CLMH-REIMB-AMT	Claim Payment Amount	138	148	11	X(11)	The amount that Medicare paid on the claim.
38	FILLER	Delimiter	149	149	1	X(01)	; (Semi colon)
39	CLMH-BENE-PMT-COINSRNC-AMT	Claim Beneficiary Payment Coinsurance Amount	150	155	6	X(6)	An amount identifying the portion of cost that is the responsibility of a beneficiary for payment.
40	FILLER	Delimiter	156	156	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
41	CLMH-RCPNT-PMT-DDCTBL-PD-AMT	Claim Recipient Payment Deductible Paid Amount	157	164	8	X(08)	The amount of money the beneficiary paid towards an annual deductible.
42	FILLER	Delimiter	165	165	1	X(01)	; (Semi colon)
43	CLMH-APO-RED-AMT	Advanced Payment Option Reduction Amount	166	173	8	X(08)	Total payment amount with PBP reduction percent applied. (For DC, Benefit Enhancement “1”).
44	FILLER	Delimiter	174	174	1	X(01)	; (Semi colon)
45	CLMH-TCC-RED-AMT	Total Care Capitation Payment Reduction Amount	175	182	8	X(08)	(For DC, Benefit Enhancement “5”).
46	FILLER	Delimiter	183	183	1	X(01)	; (Semi colon)
47	CLMH-PCC-RED-AMT	Primary Care Capitation Payment Reduction Amount	184	191	8	X(08)	(For DC, Benefit Enhancement “8”).
48	FILLER	Delimiter	192	192	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
49	CLMH-DRG-CODE	Diagnosis Related Group Code	193	195	3	9(03)	This code indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
50	FILLER	Delimiter	196	196	1	X(01)	; (Semi colon)
51	CLMH-DGNS-ADMITTING	Admitting Diagnosis Code	197	203	7	X(07)	The ICD-9/10 diagnosis code identifying the illness or disability for which the beneficiary was admitted.
52	FILLER	Delimiter	204	204	1	X(01)	; (Semi colon)
53	CLMH-DGNS-EXTERNAL	DGNS External	205	211	7	X(07)	The ICD-9/ICD-10 diagnosis code which describes the external cause of the injury. *Note: CWF is using external cause of injury first diagnosis code.*
54	FILLER	Delimiter	212	212	1	X(01)	; (Semi colon)
55	CLMH-PAT-VISIT-REAS1	Patient Visit Reason 1	213	219	7	X(07)	Diagnosis code for patient's first visit.
56	FILLER	Delimiter	220	220	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
57	CLMH-PAT-VISIT-REAS2	Patient Visit Reason 2	221	227	7	X(07)	Diagnosis code for patient's second visit.
58	FILLER	Delimiter	228	228	1	X(01)	; (Semi colon)
59	CLMH-PAT-VISIT-REAS3	Patient Visit Reason 3	229	235	7	X(07)	Diagnosis code for patient's third visit.
60	FILLER	Delimiter	236	236	1	X(01)	; (Semi colon)
61	CLMH-PRCDR-DATA		237	661	425		N/a
62	CLMH-PRCDR-ENTRY	Procedure Entry	237	243	8		Procedure Codes and Dates Occurs 25 times.
63	CLMH-PRCDR-CD	Procedure Code	237	243	7	X(07)	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim.
64	FILLER	Delimiter	244	244	1	X(01)	; (Semi colon)
65	CLMH-PRCDR-DT	Procedure Date	245	252	8	YYYY MMDD	The date the indicated procedure was performed.
66	FILLER	Delimiter	253	253	1	X(01)	; (Semi colon)
67	CLMH-DIAG-DATA		662	911	250		

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
68	CLMH-DIAG-ENTRY	Diagnosis Entry	662	671	10		Diagnosis Codes and POA indicators. Occurs 25 times.
69	CLMH-DIAG-CODE	Diagnosis Code	662	668	7	X(07)	The patient's ICD-9/ICD-10 diagnosis code.
70	FILLER	Delimiter	669	669	1	X(01)	; (Semi colon)
71	CLMH-DIAG-POA-IND	Diagnosis Code Present on Admission Indicator	670	670	1	X(01)	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility.
72	FILLER	Delimiter	671	671	1	X(01)	; (Semi colon)
73	CLMH-DETAIL-LINES	Detail Lines	912	914	3	9(03)	Number of line items on claim.
74	FILLER	Delimiter	915	915	1	X(01)	; (Semi colon)
75	CLMH-PATIENT-NUM	Patient Control Number	916	935	20	X(20)	Patient Control Number
76	FILLER	Delimiter	936	936	1	X(01)	; (Semi colon)
77	FILLER1	Filler	937	981	45	X(45)	Filler

Table 89: CKCC Weekly TCC/QCP Weekly Reduction File Detail

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CLML-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"
2	FILLER	Delimiter	5	5	1	X(01)	; (Semi colon)
3	CLML-LINE-NUMBER	Claim Line Number	6	8	3	9(03)	This number is a sequential number that identifies a specific claim line.
4	FILLER	Delimiter	9	9	1	X(01)	; (Semi colon)
5	CLML-REV-CD	Revenue Code	10	13	4	9(04)	Claim Revenue center code identifies a specific accommodation, ancillary service, or billing calculation. Note: Include REV Code 0001.
6	FILLER	Delimiter	14	14	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
7	CLML-RNDRG-PRVDR-TAX-NUM	Rendering Provider Tax Number	15	24	10	X(10)	The rendering provider's Internal Revenue Employer Identification number or Social Security number. Note: Billing TIN is always the same as Rendering TIN for Part B.
8	FILLER	Delimiter	25	25	1	X(01)	; (Semi colon)
9	CLML-RNDRG-PRVDR-NPI-NUM	Rendering Provider National Provider Identifier Number	26	35	10	X(10)	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI. Note: This will only apply to Part B.
10	FILLER	Delimiter	36	36	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
11	CLML-DGNS-CD-1	Claim Line Diagnosis First Code	37	43	7	X(07)	The first of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
12	FILLER	Delimiter	44	44	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
13	CLML-DGNS-CD-2	Claim Line Diagnosis Second Code	45	51	7	X(07)	The second of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
14	FILLER	Delimiter	52	52	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
15	CLML-DGNS-CD-3	Claim Line Diagnosis Third Code	53	59	7	X(07)	The third of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
16	FILLER	Delimiter	60	60	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
17	CLML-DGNS-CD-4	Claim Line Diagnosis Fourth Code	61	67	7	X(07)	The fourth of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
18	FILLER	Delimiter	68	68	1	X(01)	; (Semi colon)
19	CLML-FROM-DATE	Claim Line From Date	69	76	8	YYYY MMDD	This is the date the service associated with the line item began. UPDATE: CWF will carry the detail line item date for Part A in both the From and Thru Date.
20	FILLER	Delimiter	77	77	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
21	CLML-THRU-DATE	Claim Line Thru Date	78	85	8	YYYY MMDD	This is the date the service associated with the line item ended.
22	FILLER	Delimiter	86	86	1	X(01)	; (Semi colon)
23	CLML-SRVC-UNIT-QTY	Claim Line Service Unit Quantity	87	93	7	9(07)	Total units associated with services needing unit reporting such as number of covered days in a particular accommodation, miles, Anesthesia times the units and number of oxygen or blood units.
24	FILLER	Delimiter	94	94	1	X(01)	; (Semi colon)
25	CLML-TOT-CHRG-AMT	Claim Line Total Charge Amount	95	105	11	X(11)	Total submitted charge for line item. Note: CWF will also be providing charges for non-covered and denied services.
26	FILLER	Delimiter	106	106	1	X(01)	; (Semi colon)
27	CLML-ALOWD-CHRG-AMT	Claim Line Allowed Charge Amount	107	114	8	X(08)	The amount Medicare approved for payment to the provider. Note: Part B only
28	FILLER	Delimiter	115	115	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
29	CLML-CVRD-PD-AMT	Claim Line Covered Paid Amount	116	126	11	X(11)	This is the amount Medicare reimbursed the provider for covered services associated with the claim-line and is based on the Total Charge minus the Non-Covered Charge.
30	FILLER	Delimiter	127	127	1	X(01)	; (Semi colon)
31	CLML-APO-RED-AMT	Advanced Payment Option Reduction Amount	128	135	8	X(08)	(For DC, Benefit Enhancement “1”).
32	FILLER	Delimiter	136	136	1	X(01)	; (Semi colon)
33	CLML-TCC-RED-AMT	Total Care Capitation Reduced Amount	137	144	8	X(08)	(For DC, Benefit Enhancement “5”).
34	FILLER	Delimiter	145	145	1	X(01)	; (Semi colon)
35	CLML-PCC-RED-AMT	Primary Care Capitation Payment Reduction Amount	146	153	8	X(08)	Total payment amount with PCC reduction percent applied. (For DC, Benefit Enhancement “8”).
36	FILLER	Delimiter	154	154	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
37	CLML-HCPC-CD	Healthcare Common Procedure Coding System (HCPCS) Code	155	159	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
38	FILLER	Delimiter	160	160	1	X(01)	; (Semi colon)
39	CLML-HCPC-MODIFIER1	HCPCS First Modifier Code	161	162	2	X(02)	This is the first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
40	FILLER	Delimiter	163	163	1	X(01)	; (Semi colon)
41	CLML-HCPC-MODIFIER2	HCPCS Second Modifier Code	164	165	2	X(02)	This is the second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
42	FILLER	Delimiter	166	166	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
43	CLML-HCPC-MODIFIER3	HCPCS Third Modifier Code	167	168	2	X(02)	This is the third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
44	FILLER	Delimiter	169	169	1	X(01)	; (Semi colon)
45	CLML-HCPC-MODIFIER4	HCPCS Fourth Modifier Code	170	171	2	X(02)	This is the fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
46	FILLER	Delimiter	172	172	1	X(01)	; (Semi colon)
47	CLML-HCPC-MODIFIER5	HCPCS Fifth Modifier Code	173	174	2	X(02)	This is the fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. *Note: This applies only to Part A.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
48	FILLER	Delimiter	175	175	1	X(01)	; (Semi colon)
49	FILLER	Filler	176	206	31	X(31)	

Appendix E: KCC Pass-Through File

KCC Weekly Capitated (QCP) Reduction File:

The following file is prepared by CWF from 01/01/2021 and provided to RACS utilizing EFT; this file is then moved from RACS via EFT to the Entities.

Table 90: KCC Pass-Through Files

Description	Frequency	Filename	File Format	Logical Record Length	Size Estimate	Scheduled Date
Weekly TCC/QCP Reduction File	Weekly	P#EFT.ON.ACOT.K****.QCPRC.Dyymmdd.Thhmmsst	Text	800 Bytes	TBD	TBD

The file naming convention for the Weekly AIPBP Reduction File, sent by the CWF to Entities, will be P#EFT.ON.ACOT.K****.QCPRC.Dyymmdd.Thhmmsst for the KCC Entities.

The Weekly QCP Reduction filename in the ACO's mailbox will be P.K****.QCPC.RP.Dyymmdd.Thhmmsst.

Note: CWF will send both "CLMH-MBI" and "CLMH-HIC-NUM" as the beneficiary identifiers in the KCC Weekly QCP Reduction file during the New Medicare Card Project transition period. After the end of the transition period (December 2019), only "CLMH-MBI" will be populated and "CLMH-HIC-NUM" will be populated as blanks.

Table 91: KCC Entities Weekly QCP Reduction File Layout

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CLMH-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"
2	FILLER	Delimiter	5	5	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
3	CLMH-CNTRCTR-NUM	Contractor Number	6	10	5	X(05)	Identification number of contractor submitting claim.
4	FILLER	Delimiter	11	11	1	X(01)	; (Semi colon)
5	CLMH-ACO-IDENTIFIER		12	22	10	X(11)	ACO identification number.
6	CLMH-QUAL-ID	ACO ID	12	12	1	X(01)	
7	FILLER	Delimiter	13	13	1	X(01)	; (Semi colon)
8	CLMH-ACO-ID-NUMBER	ACO NUMBER	14	22	9	X(09)	
9	FILLER	Delimiter	23	23	1	X(01)	; (Semi colon)
10	CLMH-MEDICARE-PART	Claim Type	24	28	5	X(05)	Part A or Part B paid for the claim.
11	FILLER	Delimiter	29	29	1	X(01)	; (Semi colon)
12	CLMH-MBI	Medicare Beneficiary Identifier	30	40	11	X(11)	MBI is a beneficiary identifier.
13	FILLER	Delimiter	41	41	1	X(01)	; (Semi colon)
14	CLMH-DCN	DCN	42	64	23	X(23)	Carrier assigned Document Control Number for claim.
15	FILLER	Delimiter	65	65	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
16	CLMH-XREF-DCN	XREF DCN	66	88	23	X(23)	Cross-reference Document Control Number assigned to claim. *Note: This field only applies to Part A.*
17	FILLER	Delimiter	89	89	1	X(01)	; (Semi colon)
18	CLMH-FROM-DT	From Date	90	97	8	YYYY MMDD	This date is the first day on the billing statement that covers services rendered to the beneficiary. This date is also known as “Statement Covers From Date”. *Note: This applies only to Part A.*
19	FILLER	Delimiter	98	98	1	X(01)	; (Semi colon)
20	CLMH-THRU-DT	Thru Date	99	106	8	YYYY MMDD	This date is the last day on the billing statement that covers services rendered to the beneficiary. This date is also known as the “Statement Covers Through Date”. *Note: This applies to only Part A.*

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
21	FILLER	Delimiter	107	107	1	X(01)	; (Semi colon)
22	CLMH-PVDR-CCN	Provider CCN	108	113	6	X(06)	The CCN for the ACO Provider. This number verifies that a provider has been Medicare-certified for a particular type of services.
23	FILLER	Delimiter	114	114	1	X(01)	; (Semi colon)
24	CLMH-PVDR-NPI	Provider NPI	115	124	10	X(10)	NPI Number is a unique identification number for covered health care providers. Covered health care providers must use the NPIs in administrative and financial transactions.
25	FILLER	Delimiter	125	125	1	X(01)	; (Semi colon)
26	CLMH-TYPE-OF-BILL	Type of Bill	126	131	6	X(06)	A code that indicates the specific type of claim (Inpatient, Outpatient, adjustments, voids, etc.).

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
27	CLMH-BILL-FACILITY	Bill Facility	126	126	1	X(01)	This code is the first digit of the type of bill (TOB1), and is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are: 1 = Hospital 2 = SNF 3 = Home Health Agency (HHA) 4 = Religious non-medical (hospital) 5 = Religious non-medical (extended care) 6 = Intermediate care 7 = Clinic or hospital-based renal dialysis facility 8 = Specialty facility or Ambulatory Surgical Center (ASC) surgery 9 = Reserved
28	FILLER	Delimiter	127	127	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
29	CLMH-BILL-CATEGORY	Bill Category	128	128	1	X(01)	This code is the second digit of the type of bill (TOB2), and it is used to indicate with greater specificity where the service was provided (e.g. a department within a hospital) Claim Service Classification Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Service-classification-Type-Code).
30	FILLER	Delimiter	129	129	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
31	CLMH-BILL-FREQUENCY	Bill Frequency	130	130	1	X(01)	This is the third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided). Claim Frequency Codes are available at the RESDAC site (http://www.resdac.org/cms-data/variables/Claim-Frequency-Code).
32	FILLER	Delimiter	131	131	1	X(01)	; (Semi colon)
33	CLMH-ADJSMT-TYPE-CD	Adjustment Type Code	132	132	1	X(01)	This code indicates whether the claim is an original, cancellation, or adjustment claim. Claim Adjustment Type Codes are: 0=Original Claim 1=Credit 2=Debit
34	FILLER	Delimiter	133	133	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
35	CLMH-ADJUST-REASON-CODE	Adjustment Reason Code	134	136	1	X(03)	Reason code for claim adjustment, for example: • IUR • Beneficiary Alignment Change • Provider Alignment Change • Other
36	FILLER	Delimiter	137	137	1	X(01)	; (Semi colon)
37	CLMH-REIMB-AMT	Claim Payment Amount	138	148	11	X(11)	The amount that Medicare paid on the claim.
38	FILLER	Delimiter	149	149	1	X(01)	; (Semi colon)
39	CLMH-BENE-PMT-COINSRNC-AMT	Claim Beneficiary Payment Coinsurance Amount	150	155	6	X(6)	An amount identifying the portion of cost that is the responsibility of a beneficiary for payment.
40	FILLER	Delimiter	156	156	1	X(01)	; (Semi colon)
41	CLMH-RCPNT-PMT-DDCTBL-PD-AMT	Claim Recipient Payment Deductible Paid Amount	157	164	8	X(08)	The amount of money the beneficiary paid towards an annual deductible.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
42	FILLER	Delimiter	165	165	1	X(01)	; (Semi colon)
43	CLMH-APO-RED-AMT	Advanced Payment Option Reduction Amount	166	173	8	X(08)	Total payment amount with PBP reduction percent applied. (For DC, Benefit Enhancement “1”).
44	FILLER	Delimiter	174	174	1	X(01)	; (Semi colon)
45	CLMH-TCC-RED-AMT	Total Care Capitation Payment Reduction Amount	175	182	8	X(08)	(For DC, Benefit Enhancement “5”).
46	FILLER	Delimiter	183	183	1	X(01)	; (Semi colon)
47	CLMH-PCC-RED-AMT	Primary Care Capitation Payment Reduction Amount	184	191	8	X(08)	(For DC, Benefit Enhancement “8”).
48	FILLER	Delimiter	192	192	1	X(01)	; (Semi colon)
49	CLMH-DRG-CODE	Diagnosis Related Group Code	193	195	3	9(03)	This code indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
50	FILLER	Delimiter	196	196	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
51	CLMH-DGNS-ADMITTING	Admitting Diagnosis Code	197	203	7	X(07)	The ICD-9/10 diagnosis code identifying the illness or disability for which the beneficiary was admitted.
52	FILLER	Delimiter	204	204	1	X(01)	; (Semi colon)
53	CLMH-DGNS-EXTERNAL	DGNS External	205	211	7	X(07)	The ICD-9/ICD-10 diagnosis code which describes the external cause of the injury. *Note: CWF is using external cause of injury first diagnosis code.*
54	FILLER	Delimiter	212	212	1	X(01)	; (Semi colon)
55	CLMH-PAT-VISIT-REAS1	Patient Visit Reason 1	213	219	7	X(07)	Diagnosis code for patient's first visit.
56	FILLER	Delimiter	220	220	1	X(01)	; (Semi colon)
57	CLMH-PAT-VISIT-REAS2	Patient Visit Reason 2	221	227	7	X(07)	Diagnosis code for patient's second visit.
58	FILLER	Delimiter	228	228	1	X(01)	; (Semi colon)
59	CLMH-PAT-VISIT-REAS3	Patient Visit Reason 3	229	235	7	X(07)	Diagnosis code for patient's third visit.
60	FILLER	Delimiter	236	236	1	X(01)	; (Semi colon)
61	CLMH-PRCDR-DATA		237	661	425		

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
62	CLMH-PRCDR-ENTRY	Procedure Entry	237	243	8		Procedure Codes and Dates Occurs 25 times.
63	CLMH-PRCDR-CD	Procedure Code	237	243	7	X(07)	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim.
64	FILLER	Delimiter	244	244	1	X(01)	; (Semi colon)
65	CLMH-PRCDR-DT	Procedure Date	245	252	8	YYYY MMDD	The date the indicated procedure was performed.
66	FILLER	Delimiter	253	253	1	X(01)	; (Semi colon)
67	CLMH-DIAG-DATA		662	911	250		
68	CLMH-DIAG-ENTRY	Diagnosis Entry	662	671	10		Diagnosis Codes and POA indicators. Occurs 25 times.
69	CLMH-DIAG-CODE	Diagnosis Code	662	668	7	X(07)	The patient's ICD-9/ICD-10 diagnosis code.
70	FILLER	Delimiter	669	669	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
71	CLMH-DIAG-POA-IND	Diagnosis Code Present on Admission Indicator	670	670	1	X(01)	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility.
72	FILLER	Delimiter	671	671	1	X(01)	; (Semi colon)
73	CLMH-DETAIL-LINES	Detail Lines	912	914	3	9(03)	Number of line items on claim.
74	FILLER	Delimiter	915	915	1	X(01)	; (Semi colon)
75	CLMH-PATIENT-NUM	Patient Control Number	916	935	20	X(20)	Patient Control Number
76	FILLER	Delimiter	936	936	1	X(01)	; (Semi colon)
77	FILLER1	Filler	937	981	45	X(45)	Filler

Table 92: KCC QCP Weekly Reduction File Detail

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
1	CLML-RECORD-TYPE	Record Type	1	4	4	X(04)	Transaction ID Valid Values: "CLMH" "CLML"
2	FILLER	Delimiter	5	5	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
3	CLML-LINE-NUMBER	Claim Line Number	6	8	3	9(03)	This number is a sequential number that identifies a specific claim line.
4	FILLER	Delimiter	9	9	1	X(01)	; (Semi colon)
5	CLML-REV-CD	Revenue Code	10	13	4	9(04)	Claim Revenue center code identifies a specific accommodation, ancillary service, or billing calculation. Note: Include REV Code 0001.
6	FILLER	Delimiter	14	14	1	X(01)	; (Semi colon)
7	CLML-RNDRG-PRVDR-TAX-NUM	Rendering Provider Tax Number	15	24	10	X(10)	The rendering provider's Internal Revenue Employer Identification number or Social Security number. Note: Billing TIN is always the same as Rendering TIN for Part B.
8	FILLER	Delimiter	25	25	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
9	CLML-RNDRG-PRVDR-NPI-NUM	Rendering Provider National Provider Identifier Number	26	35	10	X(10)	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI. Note: This will only apply to Part B.
10	FILLER	Delimiter	36	36	1	X(01)	; (Semi colon)
11	CLML-DGNS-CD-1	Claim Line Diagnosis First Code	37	43	7	X(07)	The first of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
12	FILLER	Delimiter	44	44	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
13	CLML-DGNS-CD-2	Claim Line Diagnosis Second Code	45	51	7	X(07)	The second of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
14	FILLER	Delimiter	52	52	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
15	CLML-DGNS-CD-3	Claim Line Diagnosis Third Code	53	59	7	X(07)	The third of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
16	FILLER	Delimiter	60	60	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
17	CLML-DGNS-CD-4	Claim Line Diagnosis Fourth Code	61	67	7	X(07)	The fourth of four allowable ICD-9/10 diagnosis codes identifying the beneficiary's illness or disability. *Note: Currently, only one diagnosis code is being transmitted in CABEHUBC and future expansion will be made to accommodate diagnosis pointers to populate other 3 diagnosis codes from header. Spaces will be populated until future expansion of transmit record.*
18	FILLER	Delimiter	68	68	1	X(01)	; (Semi colon)
19	CLML-FROM-DATE	Claim Line From Date	69	76	8	YYYY MMDD	This is the date the service associated with the line item began. *UPDATE: CWF will carry the detail line item date for Part A in both the From and Thru Date.*
20	FILLER	Delimiter	77	77	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
21	CLML-THRU-DATE	Claim Line Thru Date	78	85	8	YYYY MMDD	This is the date the service associated with the line item ended.
22	FILLER	Delimiter	86	86	1	X(01)	; (Semi colon)
23	CLML-SRVC-UNIT-QTY	Claim Line Service Unit Quantity	87	93	7	9(07)	Total units associated with services needing unit reporting such as number of covered days in a particular accommodation, miles, Anesthesia times the units and number of oxygen or blood units.
24	FILLER	Delimiter	94	94	1	X(01)	; (Semi colon)
25	CLML-TOT-CHRG-AMT	Claim Line Total Charge Amount	95	105	11	X(11)	Total submitted charge for line item. *Note: CWF will also be providing charges for non-covered and denied services.*
26	FILLER	Delimiter	106	106	1	X(01)	; (Semi colon)
27	CLML-ALOWD-CHRG-AMT	Claim Line Allowed Charge Amount	107	114	8	X(08)	The amount Medicare approved for payment to the provider. Note: Part B only
28	FILLER	Delimiter	115	115	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
29	CLML-CVRD-PD-AMT	Claim Line Covered Paid Amount	116	126	11	X(11)	This is the amount Medicare reimbursed the provider for covered services associated with the claim-line and is based on the Total Charge minus the Non-Covered Charge.
30	FILLER	Delimiter	127	127	1	X(01)	; (Semi colon)
31	CLML-APO-RED-AMT	Advanced Payment Option Reduction Amount	128	135	8	X(08)	(For DC, Benefit Enhancement “1”).
32	FILLER	Delimiter	136	136	1	X(01)	; (Semi colon)
33	CLML-TCC-RED-AMT	Total Care Capitation Reduced Amount	137	144	8	X(08)	(For DC, Benefit Enhancement “5”).
34	FILLER	Delimiter	145	145	1	X(01)	; (Semi colon)
35	CLML-PCC-RED-AMT	Primary Care Capitation Payment Reduction Amount	146	153	8	X(08)	Total payment amount with PCC reduction percent applied. (For DC, Benefit Enhancement “8”).
36	FILLER	Delimiter	154	154	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
37	CLML-HCPC-CD	Healthcare Common Procedure Coding System (HCPCS) Code	155	159	5	X(05)	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
38	FILLER	Delimiter	160	160	1	X(01)	; (Semi colon)
39	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
40	CLML-HCPC-MODIFIER1	HCPCS First Modifier Code	161	162	2	X(02)	This is the first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
41	FILLER	Delimiter	163	163	1	X(01)	; (Semi colon)
42	CLML-HCPC-MODIFIER2	HCPCS Second Modifier Code	164	165	2	X(02)	This is the second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
43	FILLER	Delimiter	166	166	1	X(01)	; (Semi colon)

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
44	CLML-HCPC-MODIFIER3	HCPCS Third Modifier Code	167	168	2	X(02)	This is the third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
45	FILLER	Delimiter	169	169	1	X(01)	; (Semi colon)
46	CLML-HCPC-MODIFIER4	HCPCS Fourth Modifier Code	170	171	2	X(02)	This is the fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
47	FILLER	Delimiter	172	172	1	X(01)	; (Semi colon)
48	CLML-HCPC-MODIFIER5	HCPCS Fifth Modifier Code	173	174	2	X(02)	This is the fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service. Note: This applies only to Part A.

Element #	Claim Field Label	Claim Field Name	Start Position	End Position	Data Length	Format	Claim Field Description
49	FILLER	Delimiter	175	175	1	X(01)	; (Semi colon)
50	FILLER	Filler	176	206	31	X(31)	

Referenced Documents

Title	Document Number	Issued
CME Data Dictionary	CME Data Dictionary 20100715.xlsx	12/21/2017
ACO-OS Operations & Maintenance Manual (OMM)	3-ITSD-DCO-SOM-0063 V3.8	10/04/2018
Change Request ACO_0239: FFS SSM Bene File	ACO_0239 FFS SSM Bene File.docx	03/23/2015
Change Request ACO_0240: FFS SSM Provider File	ACO_0240 FFS SSM Provider File.docx	03/23/2015
Change Request ACO_0302: Addition of All-Inclusive Population Based Payment (AIPBP) to NGACO	ACO_0302	02/17/2016
Change Request ACO_0441: FFS SSM Bene and Provider File	ACO_0441	03/12/2018
Change Request ACO_0487: Generate a standalone VT APM Bene File to FFS SSM	ACO_0487	03/12/2018

Acronyms

Term	Definition
ACO	Accountable Care Organization
ACO-OS	Accountable Care Organization – Operational System
AIPBP	All Inclusive Population Based Payment
AMCP	Adjusted Monthly Capitated Payment
APO	Advanced Payment Option
ASC	Ambulatory Surgical Center
BENE	Beneficiary
CAH	Critical Access Hospital
CCN	CMS Certification Number
CDS	Companion Data Services
CEC	Comprehensive ESRD Care
CHAR	Character
CKCC	Comprehensive Kidney Care Contracting
CME	Common Medicare Environment
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
ConOps	Concept of Operations
CWF	Common Working File
DCE	Direct Contracting Entity
DME	Durable Medical Equipment
EFT	Electronic File Transfer
ESCO	ESRD Care Organization
FFS	Fee-For-Service
GTL	Government Team Lead
HHA	Home Health Agency
HICN	Health Insurance Claim Number
HP	Hewlett Packard
IC	Innovation Center
ICD	Interface Control Document
ID	Identifier

Term	Definition
IDR	Integrated Data Repository
IPPS	Inpatient Prospective Payment System
IRF	Inpatient Rehabilitation Facilities
KCC	Kidney Care Choice
KCF	Kidney Care First
LILS	Legislative IT Lifecycle Support
MAC	Medicare Administrative Contractor
MA OEP	Medicare Advantage Open Enrollment Period
MBD	Medicare Beneficiary Database
MCS	Multi-Carrier System
NGACO	Next Generation Accountable Care Organization
NGD	Next Generation Desktop (1-800-Medicare)
NPI	National Provider Identifier
OMM	Operations & Maintenance Manual
PBA	Performance-Based Adjustment
PBP	Population-Based Payment
PCC	Primary Care Capitation
PCF	Primary Care First
PHI	Protected Health Information
PII	Personally Identifiable Information
POC	Point of Contact
PY	Performance Year
QCP	Quarterly Capitative Payment
RACS	Receipt and Control System
RRB	Railroad Retirement Board
RTI	Research Triangle Institute
SDD	System Design Document
SIP	Seriously Ill Population
SNF	Skilled Nursing Facility
SSM	Shared System Maintainer
TBD	To be determined
TCC	Total Care Capitation

Term	Definition
TPCP	Total Primary Care Payment
TIN	Tax Identification Number
VDC	Virtual Data Center
VMS	ViPS Medicare System (VMS)
VT APM	Vermont All Payer Model

Glossary

Term	Definition
Advanced Payment Option	An adjusted percentage of the Medicare FFS revenues earned by each Direct Contracting/Entity. The adjustment is based on submitted and payable claims for the services delivered to aligned beneficiaries.
All Inclusive Population Based Payment	Each year, NGACO/VT APM/Direct Contracting/CKCC/KCF Entities will select a payment mechanism for the upcoming performance year. If an ACO selects AIPBP, the ACO will have written agreements regarding capitation with AIPBP-participating Participants and Preferred Providers.
Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefits	CMS will make available to qualified Direct Contracting and KCF/CKCC Entities, a waiver of the requirement that beneficiaries who elect the Medicare Hospice Benefit give up their right to receive curative care (sometimes referred to as “conventional care”) as a condition of electing the hospice benefit. All expenditures incurred by Medicare on behalf of such beneficiaries, whether for hospice or other non-hospices services, would be included as part of Total Cost of Care for the relevant performance year.
Entity	Unique for Direct Contracting/KCC. This is a synonym to ACO/ESCO.
Home Health Homebound Waiver	CMS will make available to qualified Direct Contracting and KCF Entities, a waiver of the homebound requirement to allow for modified application for beneficiaries aligned to the entity in order to receive home health services. The entity will have greater flexibility to ensure special populations (as specified in the Direct Contracting and KCF Participation Agreement) have access to home health services in appropriate cases. Given the risk borne by the entity, the entity would be incentivized only to do so where such care would improve quality and be cost-effective from a Total Cost of Care perspective. This flexibility would aid Direct Contracting and KCF Practices in reaching their own alternative payment arrangements with home health agencies and promote innovation and greater ability of beneficiaries to return to, remain in, and receive care in their home.
Kidney Disease Education Benefit Enhancement	CMS will make available to qualified KCF Entities, the KDE waiver that would: • Waive the requirement that the KDE be performed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and allow qualified clinicians not currently allowed to bill for the benefit to furnish the services incident to the services of a participating KCF or CKCC nephrologist. • Waive the requirement that a beneficiary have Stage 4 CKD in order to test furnishing the KDE benefit to beneficiaries with CKD stage 5 and those in the first 6 months of ESRD, who can also benefit from KDE.

Term	Definition
	• Waive the requirement that KDE sessions cover the topic of delaying initiation of dialysis to allow participating nephrologists to cover this topic as “as applicable” rather than mandated, as it is not 28 Name Description relevant to beneficiaries with ESRD who have already begun dialysis. • Waive the requirement that an outcomes assessment be conducted during one of the KDE sessions; and instead to test the provision of this assessment during a subsequent evaluation and management visit with the nephrologist.
Performance-Based Adjustment	A payment methodology for the Primary Care First model based on performance in five quality and patient experience of care measures, as well as, a measure of acute hospital utilization that is calculated and applied on a quarterly basis.
Population-Based Payments	An adjusted percentage of the Medicare FFS revenues earned by each NGACO/VT APM Entity. The adjustment is based on submitted and payable claims for the services delivered to aligned beneficiaries.
Post Discharge	CMS will make available to qualified NGACO/VT APM/Direct Contracting/CKCC/KCF Entities waivers to allow “incident to” claims for home visits to non-homebound aligned beneficiaries by licensed clinicians under the general supervision—instead of direct supervision—of NGACO/VT APM/Direct Contracting/CKCC/KCF Providers/Suppliers or Preferred Providers. Licensed clinicians may be any employees, leased employees, or independent contractors who are licensed under applicable state law to perform the ordered services under physician (or other practitioner) supervision. Claims for post discharge home visits will only be allowed following discharge from an inpatient facility (including, e.g., inpatient prospective payment system (IPPS) hospitals, CAHs, SNFs, Inpatient Rehabilitation Facilities (IRF)) and will be limited to no more than one visit in the first 10 days following discharge and no more than two visits in the first 30 days following discharge. Payment of claims for these visits will be allowed as services and supplies that are incident to the service of a physician or other practitioner.
Primary Care Capitation	Each year, Direct Contracting Entities will select a payment mechanism for the upcoming performance year. If an Entity selects PCC, the Entity will have written agreements regarding capitation on certain primary care claims with PCC-participating Participants and Preferred Providers.
Primary Care First–General Component	Identifies beneficiaries who are in the non-SIP category and receive care from a PCF practitioner who is accountable for coordination and management of their care.
Professional Population-Based Payment	A payment mechanism available to PCF participants based on a group-based risk adjustment to reduce practice focus on individual risk scores.

Term	Definition
Quarterly Capitation Payments	Alternate payment/risk sharing mechanism available for CKCC and KCF entities paid out quarterly for the services performed for the CKD4, CKD5 aligned beneficiaries.
Seriously Ill Population (SIP) Component	Identifies seriously ill beneficiaries who are experiencing fragmented, uncoordinated care under Medicare FFS, deliver an intensive, episodic intervention to stabilize their clinical condition, and establish a meaningful relationship between the beneficiary and a PCF practitioner who is accountable for coordinating and managing their care in the longer term.
Telehealth Benefit enhancement for DC and KCC	CMS will make available to qualified KCF and Direct Contracting Entities, a conditional waiver that eliminates the rural geographic component of originating site requirements, allows the originating site to include a beneficiary's home, and for the use of asynchronous ("store and forward") telehealth services in the specialties of teledermatology and teleophthalmology. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunication systems in single media format do not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Payment will be permitted for services including dermatology and ophthalmology services furnished to eligible beneficiaries using asynchronous telehealth in single or multimedia formats and distant site practitioners will bill for these services using CMMI specific asynchronous telehealth codes. The distant site practitioner must be a KCE/DCE participant who has elected to participate in this benefit enhancement.
TeleHealth Benefit Enhancement for NGACO and VT APM	CMS will make available to qualified NGACO/VT APM Entities, a waiver of the requirement that beneficiaries be located in a rural area and at a specified type of originating site in order to be eligible to receive TeleHealth services. The benefit enhancement will allow payment of claims for TeleHealth services delivered by NGACO/VT APM Providers/Suppliers (Participant Providers) or Preferred Providers to aligned beneficiaries in specified facilities or at their residence regardless of the geographic location of the beneficiary.

Term	Definition
Three-day stay SNF waiver	CMS will make available to qualified NGACO/VT APM/Direct Contracting/CKCC/KCF Entities, a waiver of the three-day inpatient stay requirement prior to admission to a SNF or acute-care hospital or Critical Access Hospital (CAH) with swing-bed approval for SNF services (“swing-bed hospital”). This benefit will allow beneficiaries to be admitted to qualified Providers/Suppliers if a SNF or swing-bed hospital is on the NGACO/VT APM/Direct Contracting/CKCC/KCF Provider/Supplier list directly or with an inpatient stay of fewer than three days. The waiver will apply only to eligible aligned beneficiaries admitted to NGACO/VT APM/Direct Contracting/CKCC/KCF Providers/Suppliers or Preferred Providers.
Total Care Capitation	Each year, Direct Contracting/CKCC Entities will select a payment mechanism for the upcoming performance year. If an Entity selects TCC, the Entity will have written agreements regarding capitation with TCC-participating Participants and Preferred Providers.
Total Primary Care Payment	A payment methodology for the Primary Care First model that is designed to move away from traditional fee-for-service (FFS) payment incentives. In order to balance these incentives, this methodology includes two payment types: (1) a professional population-based payment (professional PBP) paid on a quarterly basis; and (2) a flat fee for each primary care visit, paid on a claim-by-claim basis.

Approvals

The undersigned acknowledge that they have reviewed this document and agree with the information presented within this document. Changes to this document will be coordinated with, and approved by, the undersigned, or their designated representatives.

Signature:

Date:

Print Name: Vivek Trehan

Title: Softrams IDDOC Project Manager

Role: Submitting Organization's Approving Authority

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Date:

Print Name: Tamar Zelcer

Title: OIT/ESSG/DADS – CMS ACO-OS Government Task Lead (GTL)

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Print Name: Pauline Lapin

Title: Group Director, Seamless Care Models Group

Role: CMS Business Owner

Revision History

Version	Date	Organization/POC	Description of Changes
0.1	06/01/2015	NGC/Subhaker Chigurula	Initial draft for September 2015 ACO-OS Release based on Change Request ACO_0239 (FFS SSM Bene File) and ACO_0240 (FFS SSM Provider File).
0.2	06/11/2015	NGC/Subhaker Chigurula	Updated ICD based on comments from Office of Technology Solutions (OTS), Common Working File (CWF) Application, and Multi-Carrier System (MCS) for September 2015 ACO-OS Release. Impacted CRs are ACO_0239 (FFS SSM Bene File) and CR ACO_0240 (FFS SSM Provider File).
0.3	07/01/2015	NGC/Subhaker Chigurula	Updated ICD based on comments from OTS, CWF and MCS. • Used CWF at CWF HP Host for sending NGACO Beneficiary File. • Used CWF for receiving Response File. • Used MCS at HP VDC for sending Part A/Part B NGACO Provider File • Used MCS for receiving Response File.
1.0	07/08/2015	NGC/Geoff Cummings	Baselined as Final for September 2015 Release.

Version	Date	Organization/POC	Description of Changes
1.1	05/25/2016	NGC/Subhaker Chigurula	• Updated Referenced Documents • Updated ICD Overview • Updated General Interface Requirements • Updated section 8.1.2: Interface Processing Time Requirements. • Updated Table 4: ACO-OS to NGACO Beneficiary Record Detail. • Updated Table 5: FFS SSM to ACO-OS NGACO Beneficiary Response Record Detail. • Updated Section 8.1.5.1: Interface Initiation. • Updated Table 10: ACO-OS to Part A/Part B NGACO Provider Record Detail. • Updated Table 11: FFS SSM to ACO-OS Part A/Part B NGACO Provider Response Record Detail. • Updated Glossary. • Updated Acronyms. Added Appendix B: Pass-through files
2.0	08/29/2016	NGC/Kristina Kriss	Revised to indicate “CWF” in place of “FISS” where appropriate, per FISS feedback. • Baselined as Final for September 2016 Release.
2.1	11/29/2016	NGC/Daric Bossman/ Subhaker Chigurula	For System Requirements Project: • Updated Tables 2 – 13 to include the “Start Position” column. • Updated Tables 4, 5, 10, and 11 to denote fields that contain PII/PHI. Added Weekly AIPBP Reduction File to Appendix B.
3.0	12/07/2016	NGC/Daric Bossman/ Subhaker Chigurula	• Updated Appendix B based on feedback from CMS. • Revised to indicate “CWF” in place of “FISS” where appropriate, per FISS feedback. Baselined as Final.

Version	Date	Organization/POC	Description of Changes
3.1	01/10/2018	NGC/Subhaker Chigurula	For March 2018 Release: • Changed the title to CMMI • Updated for CEC Program • Added Section 6.3: CEC Beneficiary File for FFS SSMs • Added Section 6.4: CEC Participant File for FFS SSMs
3.2	02/07/2018	Team Halfaker/Subhaker Chigurula and Aftaan White	For March 2018 Release: Updated Part A/Part B NGACO Provider File and file naming conventions.
4.0	03/07/2018	Team Halfaker/Nima Eslami and Chris Zahn	• Updated Appendix B: AIPBP Reduction File header layout • Updated CEC Participant File for FFS SSMs, valid values for record detail in Part A/B Percentage Reduction as 000. Baselined as Final for March 2018 Release.
4.1	03/26/2018	Team Halfaker/Aftaan White	For June 2018 Release: • Updated valid values for the Care Management Home Visits Benefit Enhancement for the Part A/Part B NGACO Provider File.
4.2	04/19/2018	Team Halfaker/Aftaan White	For March 2018 Release: Updated Part A/Part B NGACO Provider File and file naming conventions.
5.0	06/04/2018	Team Halfaker/Nima Eslami	Update to AIPBP pass-through file field name based on CWF feedback. Finalized for June 2018 release.

Version	Date	Organization/POC	Description of Changes
5.1	07/06/2018	Team Halfaker/ Subhaker Chigurula	For September 2018 Release: • Updated Part A/Part B NGACO/VT APM Provider File. • Updated NGACO/VT APM Beneficiary File. • Updated Response Codes and Explanations • Updated Table 14: CEC Beneficiary File Header • Updated Table 16: ACO-OS to CEC Beneficiary Record Detail Updated Table 18: CEC Beneficiary File Trailer
6.0	09/05/2018	Team Halfaker/ Subhaker Chigurula	• Updated Table 10: ACO-OS to Part A/Part B NGACO/VT APM Provider Record Detail Baselined as Final for the September 2018 release.
6.1	10/19/2018	Team Halfaker/ Subhaker Chigurula	For December 2018 Release: • Updated Appendix B: Pass-Through File • Updated NGACO Beneficiary File for FFS SSMs • Added VT APM Beneficiary File for FFS SSMs
7.0	12/06/2018	Team Halfaker/Kristina Kriss	Baselined as Final for the December 2018 release.
7.1	10/08/2019	Team Halfaker/ Subhaker Chigurula	Appendix: Pass-Through File section was updated for HICN/MBI changes.
8.0	10/22/2019	Team Halfaker/ Subhaker Chigurula	Baselined as Final for the October 2019 release.

Version	Date	Organization/POC	Description of Changes
8.1	04/09/2020	Softrams/ Raajita Tangirala	Added new Payment models for June 2020 release: • Comprehensive Kidney Care Contract Beneficiary File • Kidney Care First Beneficiary File • CKCC/KCF Provider File • Direct Contracting Beneficiary File • Direct Contracting Provider File
8.2	04/21/2020	Softrams/ Raajita Tangirala/ Lakiesha Stanley	Updated per feedback from CMMI, including adding appendices for CKCC and KCC Pass-Through Files.
8.3	05/04/2020	Softrams/ Lakiesha Stanley	Updated CKCC/KCF BE language, glossary terms, and Direct Contracting file details based on feedback from CMMI. Also added updates based on new model (PCF).
8.4	06/02/2020	Softrams/ Lakiesha Stanley/ Hema Parasuramuni	Updated the document based on Business Owner comments on V8.3. For PCF: Added the Diabetic Shoe order component benefit enhancement code as “A” in a new file DME (Diabetic Shoe Order by Nurse Practitioner) PCF Provider File that will be sent to VMS. Appendix A Response Codes are distinguished to apply to beneficiary or provider or both.